IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
FOR THE COUNTY OF YAVAPAI

STATE OF ARIZONA,
Plaintiff,
vs.
JAMES ARTHUR RAY,
Defendant.

Case No. V1300CR201080049

REPORTER'S TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE WARREN R. DARROW

TRIAL DAY TWENTY-FOUR

MARCH 30, 2011

Camp Verde, Arizona

ORIGINAL

REPORTED BY
MINA G. HUNT
AZ CR NO. 50619
CA CSR NO. 8335

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Proceedings had before the Honorable WARREN R. DARROW, Judge, taken on Wednesday, March 30, 2011, at Yavapai County Superior Court, Division Pro Tem B, 2840 North Commonwealth Drive, Camp Verde, Arizona, before Mina G. Hunt, Certified Reporter within and for the State of Arizona.

PROCEEDINGS

THE COURT: The record will show the presence of the defendant, Mr. Ray; the attorneys, and the jury.

Good morning.

Counsel -- I actually need to see counsel just here at the bench very, very briefly about a procedural matter. Could I see you at the bench, please.

(Sidebar conference.)

THE COURT: I guess is the next witness Joel Swedberg?

MR. HUGHES: Yes.

THE COURT: Diane just wanted me to mention -- my JA -- her husband flies for the same organization. I said I can't imagine that would be an issue. And she said nothing beyond that. She wanted me to mention that to you. I thought I'll do that.

Okay.

MR. HUGHES: Thank you. We don't have an objection.

MS. DO: Neither do we.

THE COURT: Thank you.

(End of sidebar conference.)

THE COURT: The state may call the next witness, please.

MR. HUGHES: Thank you, Your Honor. State calls Joel Swedberg.

THE COURT: Step to the clerk and raise you're right hand to be sworn by the clerk.

JOEL SWEDBERG,

having been first duly sworn upon his oath to tell the truth, the whole truth, and nothing but the truth, testified as follows:

THE COURT: Please be seated here at the witness stand.

Sir, would you please start by stating and spelling your full name.

THE WITNESS: Joel Swedberg; J-o-e-l, S-w-e-d-b-e-r-g.

THE COURT: Thank you.

Mr. Hughes.

MR. HUGHES: Thank you.

DIRECT EXAMINATION

BY MR. HUGHES:

Q. Sir, can you tell us what you do for a living.

A. I'm a flight paramedic for Guardian Air.

Q. And how long have you been a flight paramedic?

A. For -- since 2000. So for 11 years.

Q. And prior to becoming a flight paramedic, did you have any other medical training or experience?

A. I was a volunteer firefighter in Ganado, Arizona. I was also an EMT and then a paramedic on ground ambulance as well.

Q. And have you had to have any special training or education to become an EMT or paramedic?

A. Yes. There is a six-month EMT course and then a full year of experience on an ambulance as an EMT, at which time I was an ER tech as well at Sage Memorial Hospital.

After that time, then I went to the paramedic class. It's a full year of training. They require ACLS, which is advanced cardiac life support. And then at that time I was able to work for three years on a ground ambulance before I was eligible to sit for the flight paramedic job.

Q. And can you tell me whether -- or what the difference is between an EMT and a paramedic.

A. An EMT is termed to be a basic level, whereas a paramedic is allowed -- charged with

administering drugs, starting I.V.s, placing endotracheal tubes, intubations, that kind of thing. It's a more advanced level.

Q. And do you recall whether as part of your duties as a flight paramedic you went out to the scene of Angel Valley in Sedona area back in October of 2009?

A. I do recall.

Q. Okay. Do you know whether a report was generated by your department pertaining to that call that you went on?

A. Absolutely. Yes.

MR. HUGHES: Your Honor, may I approach?

THE COURT: Yes.

Q. BY MR. HUGHES: Sir, I'm going to show you what's been admitted as Exhibit 792 and ask if you recognize that document.

A. Yes. This is the report that was generated.

Q. In fact, is this a copy you brought to -- a cleaner copy you brought to us yesterday afternoon?

A. That is affirmative.

Q. Okay. I'm going to ask you some questions about your recollection of the events and

also about the report that you prepared.

And you'll note that there is a screen in front of you and also a big screen up there, which hopefully can let you take a look at that document. And if you have any difficulty seeing it, let me know. I can give you a photocopy to have in front of you also.

Can you see it okay?

A. Yeah. The part that's shown I can read well.

Q. Okay. We're going to -- I'm going to kind of start at the beginning. Since it's in evidence, I'd like to have you explain what the different terms and the different statements in the report mean so we can understand what this exhibit means.

So to start out with, then, can you -- can you explain, if you would, what this section right in there explains or what that says on the report.

A. So the people on the call with Guardian Air on Angel 4. My partner, Butch Ignacio. She's a registered flight nurse. My name, Joel Swedberg, I'm the flight paramedic. And Don C. is actually Don Clarke. And he is the pilot of Angel 4.

Q. And underneath -- you mentioned that you had to receive ALS training to become a paramedic. Can you tell us briefly what ALS stands for?

A. It's advanced life support. And that's the ability to defibrillate, the ability to place endotracheal tubes and administer drugs.

Q. Is Ms. Ignacio still working for Guardian Air?

A. No.

Q. Has she retired?

A. I'm not sure what her status is.

Q. And underneath that it indicates, patient condition worse. Can you tell us what that means.

A. So that is in reference to arrival at the hospital. The patient's condition was worse than when we picked the patient up.

Q. Okay. And I'll ask you some questions about that in a minute. But can you just briefly tell us what you mean by her condition was worse at arrival than at the time you picked her up.

A. She deteriorated while in flight. Whatever pathology was going on got worse as -- as we attempted to help her.

Q. Underneath it indicates a receiving and then some information below that. Can you explain

what is -- what is documented in those paragraphs.

A. So the receiving is the hospital that we took this patient to. And that's Flagstaff Medical Center. The receiving MD is Dr. Peterson, who is also our medical director for Guardian Air.

It was the closest appropriate facility that would be able to care for this patient. And then the last paragraph describes her condition on arrival at that facility at the emergency department.

Q. And can you explain what respiratory rate up 36 to 40, and then in parens it says, Kussmaul type respirations noted. What does that sentence mean?

A. So the respiratory rate had increased in between 36 and 40 times a minute. Kussmaul type respirations are not only rapid but they're very deep. Not a panting type of respiration but very much full-chest movement, complete tidal volume exchange.

Q. Do they have a distinct sound to them?

A. They do if you're not in a helicopter. You can't hear them in a helicopter.

Q. Okay. That's a good point. I'm guessing what you hear in the helicopter would be different

perhaps than what you might hear before you load the patient into the helicopter?

A. Yeah. Most of our assessment while the helicopter is running is based on visual and tactile type of assessment. Very little can be heard.

Q. What was it that led you to believe that there were Kussmaul respirations?

A. Chest expansion and the rate.

Q. And do you recall at what point you first observed the Kussmaul respirations?

A. I don't remember exactly when without looking at the rest of the chart.

Q. Okay. And we're going to go through that. I just want to get through the header first, and then we're going to work through the rest of the report.

After that it indicates, SpO2 noted. I think it says at 99 to 100 percent. What does that mean?

A. So that is her pulse oximetry. It's a tool that we use -- it's a finger probe that we place on any of the digits that gives us a concentration of oxygen in the blood of the patient.

Q. Does that probe -- does it shoot, like, a little red laser through the finger?

A. Yeah. It gives them the little "ET" finger.

Q. And after that it says, PIV remains patent and vital signs remain stable. What does that mean?

A. That's a peripheral I.V. And that means that it is still flowing. Vital signs remaining stable is a description that there's not -- the patient's condition is -- is what it is. It hasn't actually changed immensely.

Q. And what is a peripheral I.V.?

A. A peripheral I.V. is a catheter over a needle that we use to administer fluids and drugs. And it is placed in the vein that is not a central vein so that -- the distinction is that there's a valve between it and the heart.

Q. And do you -- do you know what -- can you give us an example of what a peripheral vein would be as opposed to a central vein.

A. So a peripheral vein in this case would be, like, starting an I.V. in the fold of the elbow. A central line would be placing an I.V. that would be below the external -- external

jugular and -- or subclavian vein or a femoral vein.

Q. And then the final sentence in that section says, direct admit to Trauma No. 3. Report given to doctor in ED staff.

Can you explain what that means.

A. So we arrived at the helipad, which is above the emergency department. Trauma Room 3 is a room that we use for these types of patients. It's in the main trauma bays. And Dr. Peterson was there along with the rest of the staff from the emergency department, nurses and lab and X ray and all those folk.

Q. And I believe you mentioned Dr. Peterson is the medical director for Guardian Air?

A. That's affirmative.

Q. Can you tell us what a medical director is or what they do.

A. So as a flight paramedic I operate underneath the medical director's license. He helps -- he, basically, determines what our guidelines are, what we can and cannot do and who we should call if there's something that is outside of those guidelines.

Q. Are there certain rules about whether one

person who's not a doctor gives another person? For example, oxygen?

A. Yes. That -- that would be the guidelines that I'm referring to.

Q. In other words, are these guidelines guidelines that are protocols that you need to follow regarding the administration of medical care?

A. We've stayed away from the term "protocol." But, in essence, yes.

Q. Okay. And I don't want to -- I don't want to use a legal term if it's not the right one.

Let's -- let's go over to the other side of the page. And can you explain for us what is contained in that area.

A. So that's a description of the aircraft. It's Angel 4. The tail number is 409, Gold, Alpha. It was a scene call, not scheduled, of course, an emergent transport. And it says that we treated and transported this patient.

Q. Can you tell us what an unscheduled scene call is.

A. So it's an out-of-hospital request for medical attention. There are a number of different situations that it could be, such as car

collisions, heart attacks, falls, accidents, ATV accidents. Scene call is anything that is outside of the hospital.

Q. Are there ever scheduled calls?

A. Yes.

Q. And can you tell us what a scheduled call is.

A. So a patient would be being transported typically from one hospital to another for a specific procedure or a specific type of medical treatment.

Q. And would that, then, be booked in advance, so to speak?

A. Typically some of those -- yes. They are booked in advance.

Q. And then it says emergent. What does that mean for the response code?

A. "Emergent" means that until proven otherwise it is an -- it is an emergency.

Q. And then underneath I think most of that's self-explanatory. But can you tell us what reference name, what you're referring to and what that paragraph starting with reference name -- what do we learn from that paragraph?

A. I'm sorry. I'm not clear as to which

paragraph.
Q. This paragraph right in here.
A. **Okay. So the name is a requesting agency. The location is Cornville. The county, of course, is Yavapai County. And then the rough GPS is the actual GPS coordinates that we were given for this call.**
Q. And what do you mean by the "requesting agent"? Can you tell us what a requesting agency is.
A. **So we don't self-dispatch. Someone needs to call us for assistance. And the -- the requesting agency that called us for this call is Camp Verde Fire.**
Q. Okay. And then turning down to the rest of this sort of header information, can you tell us where you came by this patient information in that section.
A. **So the -- the sex was obvious just based on assessment. The weight is an approximate weight based on looking at the patient and lifting the patient into the aircraft.**
As far as her name and that personal information, that was obtained at a later date. And I don't know how that was obtained. Barriers

to care. That's based on our assessment of the patient on arrival at the patient.
Q. And when you arrived, then, was Ms. Neuman unconscious?
A. **Yes.**
Q. And then I want to go over and ask you about the information over here. If you can tell us what that information is telling.
A. **So the -- the LD miles are loaded miles. And that's actual miles that we had in-flight from the scene to the receiving facility with the patient on board. The dispatch time is the time that we received the call. And route is the time that we departed the airport.**
At referring is the time that we landed near Sedona. At the patient is the time that we actually made contact with the patient. Leaving the referring is the time that we lifted off from the scene.
At receiving is the time that we landed at FMC. And then transfer of care is the time at which we completed and gave the care over to Dr. Peterson and the staff there in the emergency department.
Q. Can you tell us what airport you flew out

of to reach this scene?
A. **Pulliam Airport in Flagstaff.**
Q. Now, before you go through the rest of the report, can you tell us what you recall in your own memory from when you arrived or were landing at the scene of this -- of this call.
A. **There were a number of resources in the area. There -- there was another aircraft, at least one that I remember. There were multiple fire trucks. There was an incident command system that had been set up. And we were speaking to them on the radio, and they directed us as to where to land.**
Q. And do you recall approximately where you landed, what the -- the topography was or if there were buildings around, anything along those lines?
A. **There were multiple fire trucks, multiple ambulances. There was an open area that would be east of the highway that they directed us to land. There -- there were a number of small buildings around there.**
Q. And when you landed, was your -- the patient, Ms. Neuman, right at the location where you landed?
A. **There -- approximately within hundred**

yards of the aircraft.
Q. And what can you tell us -- what do you recall about Ms. Neuman and where she was and what was going on as you arrived out of your helicopter?
A. **There were a number of other prehospital care providers there. And as we approached the patient, we were receiving report from -- from those providers as to what they had encountered and what treatments that they had provided.**
Q. And can you explain to us what you mean by "prehospital care providers"?
A. **Other EMTs, firefighters and paramedics.**
Q. Do you happen to know what agency or agencies they were with?
A. **There were a number of different agencies at this particular call, and I don't remember exactly which ones.**
Q. And when you -- when you first laid eyes on Ms. Neuman, can you tell us what you observed about her. Was she standing? Was she lying? What was going on?
A. **She was on a long spine board. So she would be lying on the -- on the board, which was then placed on top of the gurney.**
Q. And what is a long spine board?

A. It's a device that we used to protect the spine. So there would be a C-collar and head blocks that would immobilize the patient. And it not only protects the spine and the neck, but it also allows us to move the patient safely if they aren't able to do so themselves.

Q. Now, I've heard of spine boards being used in, say, car crashes and that sort of thing. Was it surprising to you that a spine board was being used in a case like this?

A. Not surprising. No.

Q. And why is that?

A. The description we got from the people that were giving us report was that they hadn't seen what had happened and so they wanted to be cautious. And it's very common for people on the scene to -- to do that.

Q. And who -- who gave you the description that they hadn't seen what happened?

A. The paramedic that was giving us report.

Q. Okay. You mentioned Ms. Neuman, then, was on a spine board or a long spine board. Was she on a gurney as well?

A. Correct.

Q. And do you recall at that point seeing

other people who appeared to be in medical distress?

A. At that point my focus was entirely on the patient and -- and I was not looking around. I was trying to get a good story and -- and find out what condition this patient was actually in.

Q. And what do you recall -- and we're going to start through the report in just a minute. But what do you recall the condition was that Ms. Neuman was in?

A. As reflected in -- in the previous statement, she was not responsive or not alert. She -- she wasn't speaking. The term used was "unconscious."

Q. Okay. In that case, what we're going to do is start going through the rest of the meat and potatoes of the report. And on here it indicates scene information right -- right there. Can you tell us what is -- we're being informed about in the scene information section of your report.

A. The description is why the transport was called. It's a long-distance flight. That means that there are a number of miles to be traveled for quick transport. And then the condition of the -- the -- of the patient, time precludes ground

transport. That's why we were called, to expedite the transport of this patient.

Q. And can you explain what you mean by a condition of the patient can preclude ground transport.

A. Patients that have been assessed to be critical, the ground units, both fire departments and ambulances, can make a determination to use air to get the patient to the emergency room more rapidly.

Q. Have you heard the term or phrase called the "golden hour"?

A. Oh, yes.

Q. Can you tell us what the "golden hour" means.

A. The golden hour is in reference to -- you have a time -- you have an hour's time from the time of incident or injury until the time the patient makes it to a tertiary care center.

Q. And what's a tertiary care center?

A. A place that would be able to provide surgery, the diagnostics necessary to determine what pathologies a person has.

Q. In receiving or giving emergent medical care, do minutes and seconds count?

A. Absolutely.

Q. And is that one of the reasons, then, that an air ambulance could be used over a ground ambulance?

A. Yes.

Q. Turning to the next section, which is the chief complaint. And can you explain what that section is telling us.

Let me make sure I've got the whole thing shown here. Can you see that okay?

A. Yes.

Q. And can you tell us, then, what the -- that section tells us in the report.

A. Tachycardia describes a rapid heart rate. Hypotension describes low blood pressure. Altered level of consciousness is another way of describing unconscious. And then a description of what the report was that the patient had been exposed to at sweat lodge.

And because the patient had an altered level of consciousness, it's part of the guideline that we assume until proven otherwise that there is -- is a possible or suspected drug overdose.

Q. Is that something that you assume when there's no obvious trauma to a person?

A. Correct.
Q. Is that part of the -- the protocol or -- it's not a protocol but part of the operating guidelines that you have from Dr. Peterson?
A. Yes.
Q. And next to chief complaint it says, category cardiac arrest. Do you know what that means?
A. Can you point out where.
Okay. That was the dispatch information that we had received. When they -- when they called for the helicopter, they said that there was a cardiac arrest. And so that's what the category indicates.
Q. Do you know whether other patients at the scene had suffered from cardiac arrest?
A. I did not witness them myself. No.
Q. Would -- when you receive a dispatch to a scene of multiple casualties, do they -- does the dispatcher go through all the different possible things that are wrong with the different patients?
A. Typically they'll dispatch you to the most critical.
Q. And when you arrived on scene, who directed you, then, to Ms. Neuman?

A. The -- the people there on scene that had already been put into place incident command.
Q. And do you know whether other paramedics had treated other patients prior to your arrival at 1815?
A. Yes, they had. There's a typical procedure of going through and triaging patients and making a determination as to who goes when.
Q. And then back to the chief complaint section, it indicates, duration, three hours. Can you tell us what you mean by that.
A. So that is what was reported. Since the onset of her problems, it had been three hours until we arrived at -- at the scene.
Q. And it was -- who -- who gave you that information?
A. That would have been in the report from the ground personnel.
Q. And do you know if that information was accurate or not?
A. I do not.
Q. Underneath that it indicates, history of present illness. Can you tell us what is meant in that section or that paragraph.
A. It's a little bit more of a description

of the report that we received. It describes that the patient had been in the sweat lodge for two to three hours. Bystanders had told the -- the paramedics there that there was an altered level of consciousness.
Q. And what do you mean by "an altered level of consciousness"?
A. She wasn't speaking normally, breathing normally and acting normally.
Q. Okay. And is that -- are those things that you look for, then, as a paramedic in determining if somebody has an altered level of consciousness?
A. Yes.
Q. Okay. And I'm sorry I interrupted. Please continue. Tell us what the rest of that sentence means.
A. So then it refers back to the rapid heart rate and the low blood pressure. The paramedics on the ground had placed the patient on oxygen via nonrebreather face mask and had started an I.V. they had given her some fluid, which would typically be normal saline, for the low blood pressure that they had noted. Their assessment was that they didn't see any obvious external trauma.

Q. And then is the history, then, information that primarily you obtained from the other paramedics or EMTs on the scene?
A. Yes.
Q. Okay. And just to go through a couple of the words. Can you tell us what "tachycardia" means.
A. Tachycardia is rapid heart rate.
Q. And what would constitute a rapid heart rate or tachycardia? Is there a particular number of beats per minute?
A. Typically anything in an adult patient over -- over 100 is termed tachycardia.
Q. And then hypotension. Can you tell us what that means.
A. That means low blood pressure.
Q. And then you indicated that a -- a nasal -- a rebreather mask was used or a nasal rebreather mask. Can you tell us what that is.
A. A nonrebreather mask is an oxygen mask that covers your face. And then there's a reservoir attached to it so that you can deliver the highest concentration of oxygen possible with -- without intubating or assist ventilating the patient.

Q. And then it states PIV initiated -- you explained what PIV was -- and fluid bolus given. Can you tell us what a fluid bolus is.

A. That is fluid given in a rapid manner to address the low blood pressure and the rapid heart rate.

Q. Is -- is rapid administration of fluid something that's commonly done when a person has low blood pressure?

A. Yes. It's part of the guideline.

Q. Okay. Turning, then, to the next section of the report, past medical history, current medications, and allergies; what, if anything, do those sections tell us?

A. So we -- we were not able to obtain any information as to what other medical problems this patient might have had or any of the medications that they might have been taking -- taken or any allergies to medications that they might have had.

Q. And can you tell us why you're not able to get that information.

A. The -- the patient was not able to speak to us, and there wasn't someone there that was able to give us that information.

Q. Did anyone provide you, say, a medical

form that had that information in it for the patient?

A. No.

Q. Underneath that it indicates, neurological exam. Can you tell us what this section, the neurological exam section, tells us.

A. So it refers to level of consciousness and the patient response to pain. So, for example, when you're starting an I.V., the patient would respond to that pain from the I.V.

Q. How do you mean they would respond?

A. Typically -- well, in this particular situation, would motion away from the pain or a pull back from when the I.V. was initiated.

Q. And, Mr. Swedberg, are you familiar with the AVPU, A-V-P-U, scale for assessing in the field a patient's level of consciousness?

A. Yes.

Q. And can you tell us what that scale is.

A. "AVPU" stands for alert to verbal stimuli, to painful stimuli, or unresponsive.

Q. And how is that scale used in the field to determine a patient's level of consciousness?

A. Exactly as said. The patient might be alert to me walking in the room and saying, hello.

My name is Joel. And the patient responds. And the patient might respond to a painful stimuli, such as starting an I.V. or the patient might not respond at all and be termed "unresponsive."

Q. Is there a more precise scale other than the AVPU scale that paramedics and doctors, nurses use for assessing level of consciousness?

A. Yes.

Q. And what is that scale called?

A. It's -- it's referred in the chart as the Glasgow Coma Scale.

Q. Okay. And is that this area right down here?

A. Yes, sir.

Q. And can you explain what the Glasgow Coma Scale is noted as being in this particular case and what the significance of those numbers are.

A. The total number that was given to this patient was 7. Normal is 15. The "E" under initial is noted to be 1. And that means there was no response --

Q. Does that --

A. -- to the eye movement.

Q. I'm sorry, Mr. Swedberg. Please continue.

A. That's -- that's as low as it can get. Verbal, there was no verbal response either. And that's as low as it can get. Motors being a 5 refers to the patient moving or responding to pain but not able to follow commands.

Q. And to determine the number, then, for the GCS, or Glasgow Coma Scale, do you then add up those three scores?

A. That's correct.

Q. And then as far as level of consciousness, this information in that section, can you tell us what's depicted in that area.

A. So the patient is termed to be unresponsive, both in orientation and mentally. Chemically paralyzed says no. And because the patient is unresponsive, we have to say that she lost consciousness.

Q. And then what do neuro comments and mental mean?

A. So what we noted was some fine tremors in the upper extremities and -- you know -- that means just, basically, shaking.

Q. And then underneath that it indicates, pupils left and right constricted. What does that mean?

A. So we assessed the black part of the eye by placing a light over it. And they were pinpoint, the size of the tip of a pen.

Q. And then underneath that it indicates, Motor comments and sensory comments.

A. So we -- we noted that the patient had movement of the upper extremities and would move them in response to nauseous stimuli, such as getting close to a very noisy helicopter or having an I.V. started.

Q. And how do you mean she moved her upper extremities?

A. There -- there was movement in them, either localizing the pain or some movement.

Q. And --

A. She was not paralyzed of the upper -- upper extremities.

Q. Okay. Underneath that it indicates an airway and respiratory. Can you tell us what, if you would, what -- what those mean on the report.

A. It was patent. The airway was patent. It wasn't compromised. And "tachypnea" means rapid respirations.

Q. And what would you consider to be a rapid respiration?

A. Anything over 20.

Q. And was that part, then, of the observation that you told us about earlier about these Kussmaul respirations?

A. Yes.

Q. Now, are all rapid respirations Kussmaul?

A. No.

Q. Are all Kussmaul respirations rapid?

A. Yes.

Q. Okay. Turning to the top of the next page -- I'm afraid it's cut off a little bit on the upper left corner. But it says something by. Do you know what that is referenced to?

A. I don't.

Q. It says performed by --

A. Okay. So that's a continuation of the previous page.

Q. And is that the previous page which was talking about airway?

A. Correct.

Q. Okay. Can you tell us, then, what "performed by patient" means?

A. So her airway was patent and she was able to -- to maintain it that way.

Q. And what do "sounds left and right clear"

mean?

A. Those are in reference to lung sounds. In auscultating her lung fields, they were noted to be clear.

Q. And then underneath comments, can you tell us what that means.

A. So this is the description that my partner had obtained in assessing the patient. She stated that the patient would moan occasionally with nauseous stimuli. The airway was clear and good. Good entry. That means chest -- chest expansion was noted.

Q. And then oxygen and performed by. Can you tell us what that means.

A. So this is the liters per minute delivered, which was 15. Again, that's a nonrebreather mask. And it was performed by the EMS providers there on the scene.

Q. And under cardiovascular, can you tell us what "JVD" and "cap refill" mean?

A. JVD is in reference to jugular venous distention. And that's the vein for the neck. And we did not note any jugular vein distention.

Cap refill is a test done by merely pressing on the fingertip and watching it blanch

and then timing how long it takes for it to refill to the pink color that it was.

Q. Is there a typical number of seconds that you would expect to see for a healthy patient, a normal patient?

A. Less than two seconds.

Q. And seeing a capillary refill of greater than two seconds, does that somehow tie into this low blood pressure that you mentioned earlier?

A. It's -- it's an indication of the condition of the patient. And yes, it does -- it is affected by -- by blood pressure and circulation.

Q. And then underneath -- I think there's probably a typo in the report. Temperature 207.5. Is that an accurate number?

A. No, sir.

Q. And can -- do you have an idea how that came about?

A. Yes. This is a computer charting system. And a number was entered in Fahrenheit. But the computer defaults to Celsius. So you enter a number, and the computer recognizes it as being Celsius. As soon as you click Fahrenheit, it converts it from Celsius to Fahrenheit.

Q. So when a number was entered, the computer thought you were entering a Celsius number to start with?
A. **Correct.**
Q. And you believe a Fahrenheit number was then entered to start with?
A. **Correct.**
Q. Okay. Do you have any idea, then, what the temperature should have actually been in that category?
A. **Not at this time.**
Q. Heart tones. Can you tell us what that stands for.
A. **That describes the sounds that's heard upon auscultating over the heart -- S1, S2, the "lub dub."**
Q. And what do you mean by "auscultating over the heart"?
A. **Auscultating, listening to.**
Q. Do you use a particular piece of medical equipment to do that?
A. **Yes. We use a stethoscope.**
Q. This S1 and S2 -- can you tell us if that's a normal sound or not?
A. **Yes. It is normal.**

Q. And then comments, extremity cool to touch and slightly dusky. What do you mean by that?
A. **So her -- her arms, hands, feet, and legs were cool to touch. And dusky is a color description.**
Q. And can you tell us what you mean by dusky.
A. **It's not pink. It's a dusky color, kind of grayish, palish.**
Q. And then you indicate pulses. Can you tell us what that box tells us.
A. **So we're able to palpate weak radial pulses, both right and left, over the radial artery.**
Q. And can you show us where the radial pulse is taken.
A. **So the radial pulse is taken at the wrist, on both right and left wrist. We did not check the carotid pulse because we had a radial pulse. The femoral pulse was noted to be normal. And that's checked over the groin. And the dorsalis, which is the -- the pulses on the -- on the feet were noted to be weak.**
Q. Then going down to the next section, can you tell us what -- what is depicted in the initial physical findings. And tell us when those initial physical findings were taken or were noted.

A. **So on arrival at the patient's side, we do an initial assessment of airway breathing and circulation. And then we do a quick initial assessment of these categories that are -- that are listed.**
Q. And we've been over the Kussmaul respirations. Can you tell us what this abdominal palpation -- it says, soft, no guarding. What does that mean?
A. **So we palpate four quadrants of the abdomen -- right upper, right lower, left upper, left lower. And upon doing so the patient didn't respond. She didn't knock her hands away. She didn't flinch. She didn't move.**
Q. And in a normal, healthy patient is that something you might expect to see?
A. **No. Unless you tickle them.**
Q. Okay. And then under pelvis, can you tell us what that means.
A. **So in assessing the pelvis, the hips, didn't -- didn't see any obvious external trauma. The patient was incontinent of urine. That means**

that she had voided. And upon compression of the pelvis, there wasn't any movement. It was intact.
Q. And, now, in treating unconscious patients, is it common or uncommon to find that they've become incontinent with respect to their urine?
A. **It -- it could be a normal -- it could be a common finding. Because they're unconscious doesn't necessarily mean that they'll be incontinent. But a lot of unconscious patients are incontinent.**
Q. And then down underneath that there's a number of different pulses that say 1+ and intact. Can you tell us what that means.
A. **It's an indication that -- a normal finding would have been 2+. So that the pulses are weak but they're present.**
Q. And extremity findings. Is that referring to the I.V. in the peripheral?
A. **Correct. It means that the peripheral I.V. was placed in the right AC, which is right here where I'm showing.**
Q. And for purposes of the record, can you tell us in general what part of the body you're pointing to.

A. On the inside of the elbow where the arm folds.
Q. And what does "patents" mean?
A. It means that it's flowing and there's no signs of extravasation or leaking around into the outside of the vein.
Q. Now, this was an I.V. that Guardian started or is this an I.V. that was already in place when you arrived?
A. This was an I.V. that was already in place.
Q. And then skin. Can you tell us what's meant by the description for skin.
A. Clammy, cold. "Clammy" means not sweaty but not dry. "Cold" means cold. Cyanotic is a description of the color. Not pink but it has more of a blueish hue to it. And then no -- no signs of external trauma. The skin was intact. There wasn't any injuries noted.
Q. And would -- do you have any idea -- prior to your arrival at the patient at 6:17, do you have any idea of whether the patient had been cooled down prior to your arrival?
A. We weren't given that information.
Q. And do you know whether she had been

wetted down prior to your arrival?
A. We weren't given that information.
Q. Can you tell us what "immobilization" means.
A. So that's in -- in reference to the long spine board and the C-collar. The C-collar, which is a rigid collar that goes around the neck to protect the spine, was placed prior to our arrival. And the long spine board or long backboard was placed prior to our arrival.
Q. And then trachea?
A. The trachea is felt right above where the sternum starts, and it was noted to be midline, which means right in the middle.
Q. Now, turning back for a moment to the notations for skin. When you arrived do you know whether the patient was wrapped up in blankets or wearing jeans and a sweater? Do you know what -- what her clothing status was?
A. There were -- there was a sheet over the patient and the patient had been exposed, meaning that the clothing had been removed.
Q. And is the removal of clothing, at least in the chest area, something you would expect to see?

A. Yes.
Q. The section below where fluids before, during transport. Do you see that section down there?
A. Yes.
Q. Can you tell us what we -- we can learn from that box.
A. So prior to our arrival, the patient had received 800 cc's. And during our transport the patient received 200 cc's.
Q. Do you know what fluid the patient had received?
A. Normal saline.
Q. And 800 and 200. Does that equal out to about one liter?
A. Yes.
Q. Now, how do you know that the patient had received 800 cubic centimeters before your arrival?
A. The bags have numbers on them. And so wherever the fluid is sitting will correspond to how much fluid is left in the bag and how much fluid a patient has had.
Q. Is that something you're trained to -- to look for and note?
A. Yes.

Q. And then --
A. And verify that it matches the report that we received.
Q. And had you received a report then about the I.V.?
A. Yes.
Q. And did the information that you received from the paramedics or the EMTs about the I.V. -- did that correspond with your own observation?
A. Yes.
Q. Can you tell us what the next section over here, I.V.s prior to assessment, means.
A. So before we got there the patient had an 18-gauge I.V. started in the right AC, had received normal saline, was done by an EMS provider. And they stated that the patient improved.
Q. Now, what does "18 gauge" refer to?
A. That refers to the size of the needle and the size of the catheter.
Q. And by "catheter," are you referring to -- I think a lot of people think a catheter is just something that pertains to sort of the urinary system. Is that the same thing you're talking about?
A. No.

Q. And what are you referring to, then, by "catheter"?

A. A catheter -- an I.V. catheter is a Teflon coated -- a piece of plastic that goes over the top of a needle. And so when you start an I.V., you use a needle to penetrate the skin and vein; and then you remove the needle and leave the piece of plastic inside the vein to be able to administer whatever fluids and medications you need.

Q. And then 500 cc's an hour. Can you tell us what that means.

A. That's the rate at which the fluid was delivered.

Q. Then underneath that it indicates a -- there's a time here and then some other information going to the right of that. Can you tell us what that means.

A. So I'm not sure exactly what time that is. 1830 is 6:30. I realize that. But in reference to our presence on scene, I'd like to be able to look at when we actually arrived at the patient.

Q. And would that be information on the first page?

A. Yes, sir.

Q. Okay. So if we flip back around to the first page, is that information depicted in the -- the box to the -- this box right here?

A. Yes.

Q. Okay. And what time did you arrive with the patient?

A. So we arrived at the patient at 1817 and we left the scene at 1822. Arrived at the hospital at 1840.

Q. Okay. Does that, then, help you as far as a reference to determine what this time means down in this section of the report?

A. So at 1830 that means that the patient is in our care. And we are using this I.V., I.V. No. 1, which is the 18 gauge that's referred to up above, to administer normal saline, and we're giving this patient a bolus.

Q. And what does "bolus" mean?

A. A rapid infusion of fluid.

Q. And then underneath we have impressions and diagnosis. Can you tell us what your impressions and diagnosis are and also at what point in time that impression and diagnosis is referring to?

A. So impression/diagnosis is after we have assessed the patient. And per report there was a heat exposure from the sweat lodge. We noticed an abnormal cardiac rhythm, cardiac dysrhythmia.

Q. And what do you mean by "abnormal"? What is -- what would you consider to be normal?

A. For an adult patient anything between 60 and 100. And this was outside of that category.

Q. Okay.

A. And then altered level of consciousness, and we have not found any trauma.

Q. Now, your impressions are -- were -- for example, the impression of heat exposure. Was that consistent with the signs and symptoms that you'd seen at that point?

A. Yes, sir.

Q. Turning down, then, to activity, is it correct to say that -- well, let me ask you.

What does -- what does the "activity" stand for? And if you could kind of walk us through that -- that section.

A. So the activity has to do with our encounter with the patient. The report that we received, what we noted, and then what we did during transport.

Q. And can you tell us, then -- there's a number of bits of information that are noted all along, sort of in a column format. Can you tell us what those bits of information -- what they're referencing to and tell us whether those titles up there have anything to do with the information that's along that line that I just drew.

A. So, yeah. The information that -- that's up on top where it says time and then it has heart rate on that line, has blood pressure MAP, which means mean arterial pressure.

SaO2 is that pulse oximetry. Respirations, the rhythm that we noted on the cardiac monitor. GCS is the Glasgow coma score. Temp is the patient's temperature. And then PRTCL is the protocol that we were under.

Q. And the temperature, for example, says axillary. What does that mean? Can you tell us how you went about -- or how the temperature would be taken if it's an axillary temperature.

A. So we'd use an external thermometer and place it in the patient's armpit and obtain a -- a temperature from there.

Q. And do you know whether that temperature reading would be the same as if you took a reading,

say, inside the ear or even inside the rectum of a patient?

A. It -- it would be different. Yes.

Q. And do you have any information as to how it might be different? Does an axillary temperature read lower or higher?

A. It -- it would read lower.

Q. And then underneath that there's some -- there's some numbers. And can you kind of walk through and tell us what those numbers mean.

A. So heart rate is 140. The blood pressure initially was 126 over 85. The mean arterial pressure was 99. The pulse oximetry was 100. The patient's respiratory rate was 42 and noted to be rapid by the words "tachypnea."

The rhythm that was noted on the monitor was sinus tachycardia, and it was regular. That means rapid heart rate. The Glasgow coma score was 1, 1, and 5 to a total of 7.

Q. And I think you've already talked about the temperature and then the protocols. The protocol -- what is a general adult protocol?

A. It's the guideline that we were using at the encounter of this patient.

Q. And was that a standard guideline that

you'd use with any adult patient that you might see that week or that year?

A. Yes.

Q. Okay. Now, the blood pressure indicates 126 over 85. And you mentioned earlier that you noted low blood pressure. Are those two readings consistent?

A. So low -- 126 over 85 is not low blood pressure.

Q. Do you know then -- you had mentioned earlier in the report that -- I believe on page 1 -- that hypotension was noted. Do you know what the blood pressure was when that chief complaint of hypotension was arrived at?

A. No, I don't.

Q. Was that something, then, that you were told by EMS when you arrived?

A. Yes.

Q. And when you arrived, there was an I.V. started. Can an I.V. affect a person's blood pressure one way or the other?

A. Yes.

Q. And can you tell us how it could affect a person's blood pressure.

A. It should -- it should improve it or make

it come up.

Q. What about an I.V. that's delivering a bolus or a full open I.V.?

A. That would be the intention of it is to raise the blood pressure.

Q. Can you explain, if you would, what this information down here is referring to in the verbatim section of the report.

A. So it says, cardiac. And then it describes what we saw when we initially got on scene. EMS was close by with the patient. The patient was on a long spine board. Describes the oxygen again and the I.V. and the condition of the I.V. describes who we received report from and then what we did after that.

We loaded the patient into the aircraft and secured the patient onto the aircraft's stretcher. And it describes the conditions of the airway as being patent at this time.

We then place the patient on our equipment. We use a Philips monitor for blood pressure, pulse oximetry, and cardiac monitoring so that we can see the rate and the rhythm of the patient's heart rate.

Q. You've -- you've explained earlier quite

a few of these terms, like the "NRBM" and the "PIV." Can you tell us what IVF infusing at a wide open rate means?

A. So the I.V. bag is connected to tubing. And we have opened the clamp to allow the free flow of I.V. fluids to run in as fast as we can.

Q. Can the paramedic or the medical provider control the rate of an I.V. flow into a patient?

A. Yes. We do that by a dial clamp on that I.V. tubing.

Q. And in this case, then, was -- was that clamp opened up all the way?

A. Yes.

Q. This indicates, Sedona EMS CEP. Can you tell us what that means.

A. So it's reported that it was an emergency medical services with Sedona. And a CEP is a certified emergency paramedic.

Q. All right. Turning to the next -- actually, before I turn to the next page, I think it cuts off. Is there another time that is going to be referring to what we see in the next page?

A. Correct. So 1828 would be the beginning of the next category.

Q. Okay. And how do you determine or how

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is -- how is it determined when to start a particular category?

A. I'm sorry. Can you clarify?

Q. On this report there are a number of categories; correct?

A. Yes.

Q. And each one is separated by a different time; correct?

A. Yes.

Q. How is it that you determine whether to lump one -- information into one category or break it into different categories by different time?

A. So it's when that particular intervention or action was begun is when the time is stamped on the report.

Q. Okay. Let's go to the next one. And what was that time again?

A. 1828.

Q. Okay. And moving around the staple here, I believe it starts out with airway. Do you see that?

A. Yes.

Q. Okay. So can you tell us, then, what this section is telling us.

A. So I continued the treatment of oxygen.

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I hooked the nonrebreather mask tubing to our aircraft at a flow of 15 liters a minute.

Q. And underneath that it says, patient response unchanged. What does that mean?

A. There was no change in the patient's status. She continued as had been previously assessed.

Q. Now, for that category, which was the time, again being 1825, there are no additional readings along in that area where you had noted in the previous category, heart rate and blood pressure and that sort of thing. Can you tell us why there might be readings in one category and not readings printed out in another category.

A. So our guideline asks us to do a set of vitals, which is how we refer to the heart rate, blood pressure, and all those numbers there. When we do a different intervention such at airway, we don't -- we don't necessarily have an associated set of vitals.

Q. Moving down to the next category -- and this staple is going to be the death of me, I'm afraid -- it indicates -- it indicates a time of -- would you agree where it's cut off it says, 1835?

A. Yes.

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Q. Okay. And then there are a number of vitals indicated in that section. Can you tell us what that particular section is telling us about.

A. So the heart rate was 135. The blood pressure was 118 over 83. Pulse oximetry was 90 -- can you flip back to the previous. I think that's actually the mean arterial pressure.

Q. And actually, Mr. Swedberg, what I'll give you is a photocopy --

A. Okay.

Q. And that way you can keep track of what order these numbers are printed. Would that assist you?

Can you -- first of all, look at the photocopy and make sure it's got -- it's the same order so you can refer to the numbers on the next page.

A. Yes.

Q. Okay. So going to that next page, then, can you tell us, then, what that section means for 1835.

A. So it describes the heart rate as being 139; the blood pressure being 118 over 83; the mean arterial pressure being 95; the pulse oximetry being 99; the respiratory rate being rapid, by the

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description of tachypnea, at 35. Sinus tachycardia noted on the monitor, and it was regular.

Q. And can you tell us, then, what this pulse oximetry means.

A. Again, that's that device that we place on a patient's finger that has the red dot on it that describes the oxygen concentration of the blood.

Q. Okay. And that was a poor question on my part. Can you tell us what a normal -- if you were to put a -- assuming I'm normal and healthy, which is an assumption, can you tell me what a normal patient's pulse oximetry reading would be.

A. Anything at this altitude between 92 and 100.

Q. And then to the right of that you mentioned it's saturation of oxygen?

A. Yes.

Q. What does that 99 reading tell you?

A. It tells us that 99 percent of the patient's hemoglobin are covered with oxygen molecules.

Q. And is that something you would expect to see in a patient who is receiving oxygen?

A. Yes.

Q. Okay. Next to that it indicates -- below that there's the word "labs." Can you tell us what you mean by that.

A. So the labs obtained -- part of the altered-level-of-consciousness guideline is to obtain a blood sugar. So we did an Accu-Chek, and it was 131.

Q. And tell us what an Accu-Chek is.

A. It's a blood sugar that's obtained through a drop of blood and read through an Accu-Chek machine.

Q. Is that a machine that's carried on the aircraft with you?

A. Yes.

Q. And can you tell us what a normal healthy person's blood sugar reading you would expect to see.

A. Between 80 and 100.

Q. And then can you tell us what the rest of that text is referring to in that section.

A. So we attempted to start a second I.V., and it was unsuccessful. A second attempt was made, and it was also unsuccessful.

Q. Can you tell us why would you attempt to start a second I.V. if you already had a first one

already working.

A. Because of the patient's condition and the heart rate.

Q. And as far as the -- this reading here, 35 and tachypnea, can you tell us again what that stands for.

A. That's a rapid respiratory rate.

Q. And what would you expect to see for a normal, healthy adult as far as a respiratory rate?

A. Between 12 and 20.

Q. And then turning now to the next section. It's labeled 1845. And I believe you -- what time did you arrive at the hospital?

A. Referring back, we arrived at the hospital at 1840.

Q. Now, when you first arrived, what time does that 1840 denote as far as your arrival process at the hospital?

A. 1840 is when the skids of the helicopter touched the helipad at Flagstaff Medical Center.

Q. And does it take some time, then, from the time the skids touch down on the hospital to actually get the patient in to where nurses and doctors are?

A. Yes.

Q. And is that time when you arrived with the nurses and doctors the other time you mentioned -- referred to on the first page of the report?

A. Yes.

Q. And what time was that?

A. We arrived at the nurses and doctors at 1846.

Q. Now, turning back, then, to the page we've been referring to, this time of 1845, can you tell us what's going on when that assessment is being made.

A. So the patient is being transferred from the helipad down to Trauma Room 3. We have to go down an elevator. And as we're doing so, we obtain another blood pressure and then we administer a medication.

Q. And that medicine, naloxone, I think a doctor told us yesterday it's called "narcon"? Is that your understanding?

A. Narcan.

Q. Or Narcan?

A. Yes.

Q. And what does this 4 milligrams via I.V. push given by Swedberg?

A. So we gave the patient 4 milligrams in a syringe through the I.V. that was flowing.

Q. And what time approximately did you then give that -- that drug to the patient?

A. The time listed as 1845.

Q. And underneath that it says, med. Can you tell us what that abbreviation stands for.

A. That stands for medication.

Q. And then finally at 1900, can you tell us what the vitals are referenced in the 1900 section.

A. So the patient's heart rate is 156. The blood pressure is 159 over 103 with a mean arterial pressure of 122, a pulse oximetry of 100, a respiratory rate of 38. And it was described as fatigued. Sinus tachycardia, meaning rapid heart rate, on the monitor. It was still regular. And then the Glasgow coma score obtained at this point is 1, 1, 4.

Q. And at this point at 1900, there are doctors and nurses around the patient, as well; is that correct?

A. Yes.

Q. The rectal temperature. How was that obtained, then, at that point at 7:00 o'clock?

A. That was obtained by the emergency room

staff through the patient's rectum.
Q. Now, as far as the procedure, when you take a patient to the hospital, do you hand them over to the doctors and just leave? Or how does that process work?
A. So a report is given to the entire team that's in the emergency room -- doctors and nurses. Typically one provider will stay around and provide any additional information required while the other provider will begin to prepare for the next call or getting other information required.
Q. And do you or your colleagues ever assist the people in the emergency department with medical care once there are doctors and nurses around?
A. Yes.
Q. Is that something that's rare or is that something that's common?
A. I don't know if I could characterize it either way. It depends on the provider that's in the emergency room, the doctor, and it also depends on the provider that's on the aircraft.
Q. In this particular case, did you or your partner assist the emergency department with the medical treatment then at the 1700 time?
A. Yes. Ms. Ignacio assisted Dr. Peterson

with a procedure that's described.
Q. And can you explain for us what is described, then, in that procedure.
A. Ms. Ignacio is describing the placing of a breathing tube. It's called "orotracheal intubation." And it's a breathing tube that's placed into the trachea of the patient to be able to assist with respirations, with breathing.
Q. And in the insertion of a breathing tube, are any drugs given occasionally to patients?
A. Yes.
Q. And can you -- and do you know why the drugs would be given to a patient before or while you're inserting a breathing tube?
A. The administration of the drugs assist in the performance of this procedure.
Q. And with respect to the different vitals that we've discussed and the signs and symptoms that you observed, are they consistent with what your understanding of signs and symptoms of heat stroke would be?
MS. DO: Objection. Foundation, Your Honor.
THE COURT: Sustained.
Q. BY MR. HUGHES: Are you familiar with respect to heat stroke, what the common signs and

symptoms are?
A. Yes.
Q. Can you tell us what those are.
MS. DO: Objection, Your Honor. Foundation.
THE COURT: I'm sorry?
MS. DO: Objection. Foundation.
THE COURT: Sustained.
Q. BY MR. HUGHES: How are you familiar with the signs and symptoms?
A. Can you clarify.
Q. Can you tell us where you learned or how you learned the signs and symptoms of heat stroke.
A. In paramedic class they described signs and symptoms of heat stroke. Also as part of our recurrent training, especially living in Arizona, to be familiar with signs and symptoms of heat stroke.
And on a personal note, I've been in a sweat lodge.
Q. And the paramedic training that you've mentioned -- is that training that's required by the State of Arizona to receive your paramedic certification or paramedic license?
A. Yes, sir.
Q. And based, then, on that training, are

you familiar with the -- with the signs and symptoms of heat stroke?
MS. DO: Your Honor, objection. With all due respect, he's not a medical doctor.
THE COURT: Overruled.
You may answer that.
THE WITNESS: Yes.
Q. BY MR. HUGHES: And can you tell us what those are.
A. You -- you would expect to see no sweating, hot skin, rapid respirations, rapid heart rate, and a low blood pressure.
Q. Now, in this case your report noted that the skin in this particular case was cold and clammy?
A. Yes.
Q. Does that change your opinion as far as the signs and symptoms you observed?
A. In this case it's difficult to determine the cause of the cold and clammy skin.
Q. Are you familiar with the signs and symptoms of poisoning?
A. Yes.
Q. And how are you familiar with those signs and symptoms?

A. Through my training.
Q. And do you know -- are you familiar with, in particular, poisoning from organophosphate pesticides?
A. Yes.
Q. And can you tell us what those signs and symptoms are.
MS. DO: Objection, Your Honor. Foundation.
THE COURT: Sustained.
Q. BY MR. HUGHES: The training that you received for the signs and symptoms of pesticide poisoning -- was that part of the paramedic course that you had to take to obtain your license or certificate from the State of Arizona?
A. Yes.
Q. And in that training did they teach the signs and symptoms -- common signs and symptoms of pesticide poisoning?
A. Yes.
Q. Can you tell us what those are.
A. My recollection of them -- red as a beet, mad as a hatter, and then you tend to see a lot of production of -- of mucus.
Q. And did you see a lot of production of mucus in Ms. Neuman's case?

A. It's not been documented as so.
Q. Is that something you would expect to be documented in your report if it was there?
A. If it was present, yes.
Q. You mentioned that you'd been in a sweat lodge previously?
A. Yes, sir.
Q. And can you tell us when that was.
MS. DO: Objection. Relevance.
THE COURT: Overruled.
You may -- you may answer that.
THE WITNESS: I'm -- I'm married to a Navajo woman. And I've been in a sweat lodge several times with her family.
Q. BY MR. HUGHES: And with respect to the sweat lodge that you were in, do you recall the last time you were in one with her family?
MS. DO: Your Honor, objection to this whole line of questioning on relevance.
THE COURT: Sustained.
Q. BY MR. HUGHES: You mentioned the common signs and symptoms of pesticide poisoning. Have you ever actually seen a patient that you suspected displayed the signs and symptoms of pesticide poisoning?

A. No.
Q. How long have you been treating patients?
A. For -- since 1996.
Q. Have you ever seen a patient with signs and symptoms that you suspected to be heat stroke other than Ms. Neuman?
A. Yes.
Q. And do you have any idea how many patients that you've seen that you suspected that suffered from heat stroke?
A. I can't remember a number.
Q. More than five or less than five?
A. More than five.
Q. Mr. Swedberg, a couple other follow-up questions for you.
The administration of this Narcan. Can you -- I think the report may indicate. Can you tell us who it was that actually administered that Narcan.
A. I did.
Q. And was that pursuant, then, to this general adult protocol that you referred to earlier?
A. Not the general adult protocol. But it was pursuant to the altered-level-of-consciousness

guideline.
Q. And can you tell us what the altered-level-of-consciousness guidelines are.
A. You look for signs of trauma. You look for a blood sugar. You look for signs and symptoms that might show the need for giving Narcan for a drug overdose. And you -- you try to determine as to -- as why -- the reason for the altered level of consciousness by doing these things.
Q. And in this particular case, what were the signs and symptoms that you saw that you believed implicated that -- unconscious patient or the protocol that you mentioned?
MS. DO: Objection, Your Honor. Asked and answered.
THE COURT: Sustained.
Q. BY MR. HUGHES: Did you observe signs and symptoms that led you to believe that the protocol needed to be implemented?
MS. DO: Your Honor, same objection.
THE COURT: You may answer that.
Overruled.
THE WITNESS: Yes.
Q. BY MR. HUGHES: You mentioned a number of signs and symptoms that are in your protocol for

determining whether to administer Narcan. Did you see all of those signs and symptoms in this case?

A. Can you rephrase.

Q. I'll try. You mentioned some signs and symptoms that implicate your protocol for giving Narcan. Did you observe all of those signs and symptoms in the case of Ms. Neuman?

A. No.

Q. Can you tell us the ones that you didn't observe.

A. I didn't observe a low respiratory rate or a low respiratory effort.

Q. And what is a low respiratory effort?

A. The patient isn't trying very hard to breath.

Q. Would that be very shallow breath?

A. Shallow breathing is one indication. Yes.

Q. You mentioned this Kussmaul respiration. Would Kussmaul respirations be consistent with or inconsistent with the things you'd be looking for for administering Narcan?

A. It would be inconsistent with.

Q. And you gave us a description of Kussmaul respirations. Is there -- can you replicate what

the sound would sound like if -- if -- if you weren't in your helicopter for a patient who was exhibiting Kussmaul respirations.

A. It would sound something like --

Q. And in this particular case, Doctor, do you know why you --

MS. DO: Your Honor, I think Mr. Hughes misspoke. He said "doctor."

Q. BY MR. HUGHES: I'm sorry. I gave you a promotion. Mr. Swedberg, do you know why the patient was taken to Flagstaff Medical Center as opposed to some other hospital in the area?

A. Because they have everything that's required to make the determination as to what is wrong with the patient and make all the -- if there was trauma involved, they could do that. If there was a neuro event, they could address that, versus the other facilities in the area.

Q. Is it your understanding the other facilities may have had some limits -- limitations on the degree of care that they could provide to emergent patients?

A. For a neurology, yes.

Q. And you indicated you flew out of the Flagstaff airport. Can you tell us where you are

located, where your place of operations typically are located?

A. They're in a hangar right off the tarmac at Pulliam Airport in Flagstaff.

MR. HUGHES: Thank you, Mr. Swedberg.

THE COURT: Ladies and gentlemen, we will take the morning recess at this time. Please remember the admonition. And please be reassembled at ten after. So it'll be about 20 minutes.

And Mr. Swedberg, the rule of exclusion of witnesses has been invoked in this case. That means you -- you probably know this, but it means you cannot discuss the case or your testimony with any other witness until the trial is completely over. You really can't communicate anyway with other witnesses about the trial or your testimony until the case is completed.

Do you understand that.

THE WITNESS: Yes, sir.

THE COURT: You can talk to the lawyers, however, as long as no other witnesses are present. So you are excused, as well.

We will be in recess. Thank you.

(Recess.)

THE COURT: The record will show the presence

of Mr. Ray, the attorneys, the jury. The witness, Mr. Swedberg, has returned to the stand and he is under oath, of course.

Ms. Do.

MS. DO: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. DO:

Q. Good morning, Mr. Swedberg. Did I say that right?

A. Yes. Good morning.

Q. How are you?

A. Well. Thank you.

Q. Good. Let me start by reviewing with you your background and qualifications. Okay?

A. Yes.

Q. You'll probably need to speak up just a little louder.

A. Okay.

Q. Okay. Great. Thank you.

And so the jury knows, you and I have not met previous to you coming to court yesterday; correct?

A. Yes.

Q. And you came yesterday hoping to get on the stand and -- and we made you come back.

A. Yes.
Q. All right. You're a flight paramedic?
A. Yes.
Q. And, as you explained to the jury, there's a difference between an EMT and a paramedic; correct?
A. Yes.
Q. And if I can sum that up, essentially, a paramedic can do certain procedures that, basically, break the skin; correct?
A. Yes.
Q. Whereas an EMT cannot; is that correct?
A. Yes.
Q. And you work for Guardian Air. And I see that you are in your uniform?
A. Yes.
Q. And Guardian Air is, essentially, a transport company that has both ground services, i.e., ambulances; correct?
A. No.
Q. Oh. No. The sister company.
A. There is another division of Northern Arizona Healthcare that does have ground ambulances.
Q. Okay. Thank you for the correction.

You work for Guardian Air, which deals with aircraft; correct?
A. Yes.
Q. And on this particular date of October 8th, you were working on a flight crew that flew in a helicopter; correct?
A. Yes.
Q. You are not the pilot, though; correct?
A. No.
Q. The pilot on that day was a gentleman by the name of Don Clarke?
A. Yes.
Q. And the flight crew, in addition to the pilot, would also include you. You're the paramedic?
A. Yes.
Q. And then the registered nurse?
A. Yes.
Q. And her name is Ignacio -- or Butch Ignacio?
A. Yes.
Q. Okay. And you've been a paramedic for about 11 years; is that correct?
A. I've been a paramedic since 1996.
Q. I thought I heard 11 years. Did I misspeak?

A. I've been a flight paramedic for 11 years.
Q. Okay. Thank you. Now, I know that was a misspeak on Mr. Hughes' part. You're obviously not a medical doctor?
A. No.
Q. Your main education, training, as a paramedic is to respond to scenes and stabilize a patient, for one; correct?
A. That is part of what we do. Yes.
Q. Okay. So one of your primary duties when you respond to a scene is to find the patient and to stabilize that patient for transport to whatever medical facility; correct?
A. Yes.
Q. And, of course, if the patient's condition is life-threatening, you, as a paramedic, are permitted to take precautions or procedures like CPR; correct?
A. Yes.
Q. Intubation?
A. Yes.
Q. And the other duties that you would have would include taking a patient's vitals; correct?

A. Yes.
Q. And vitals, so we are all on the same page, include things like temperature?
A. Yes.
Q. Breathing?
A. Yes.
Q. Blood pressure?
A. Yes.
Q. And you would take vitals, and you would monitor the vitals during transport; correct?
A. Yes.
Q. All, again, to make sure that the patient is, to the best of your ability, stabilized as the person is being transported?
A. Yes.
Q. Okay. So if I -- and I mean no disrespect by this. You do not have any training as a medical doctor obviously?
A. No.
Q. So you're job, your qualifications, would not include rendering a medical diagnosis in the same manner that a medical doctor would; correct?
A. Correct.
Q. Of course, your observations about the vitals and other things are important information

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that you would collect and turn over to the doctor; correct?
A. Correct.
Q. And that information may or may not help that doctor in rendering a medical diagnosis; correct?
A. Correct.
Q. So you would agree with me that you would defer to any medical diagnosis that is rendered by a medical doctor; correct?
A. Can you rephrase.
Q. Certainly. I understand you may have personal opinions. Correct?
A. Yes.
Q. But your opinions would not override the diagnosis of a medical doctor?
A. Correct.
Q. You would defer to -- if a medical doctor, for example, came in and testified to this jury about Liz Neuman's condition, you would certainly defer to that doctor's opinion, medical diagnosis?
A. Yes.
Q. Let me ask you, Mr. Swedberg, a few questions about your contacts in this case with law

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enforcement, if I may. Okay?
A. Okay.
Q. Have you had any contact with anyone from a medical examiners' office in this case?
A. No.
Q. So you've not spoken to anyone and no one has contacted you from the Coconino Medical Examiner's Office?
A. No.
Q. In particular, you've never spoken to a medical examiner named Dr. A.L. Mosley?
A. No.
Q. Have you ever spoken to or has anyone contacted you from the Yavapai County Medical Examiner's Office?
A. No.
Q. And in particular, that would include two medical examiners, named Dr. Robert Lyon and Dr. Mark Fischione; correct?
A. I've never spoken to them.
Q. Never spoken to them. What about the Yavapai County Sheriff's Office? Prior to you coming in to court to testify to this jury, have you spoken to anyone from the Yavapai County Sheriff's Office?

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A. Not that I know of.
Q. Okay. In particular, you've never spoken to Detective Ross Diskin, the case agent in this case?
A. No.
Q. So no one from the medical examiner's office, no one from the sheriff's office, has ever during the 17 months of this case, contacted you to ask you what you saw, what you observed, as Mr. Hughes has gone through this morning?
A. No.
Q. I understand, however, that you were recently interviewed by a prosecutor in this case. Is that correct?
A. Yes.
Q. In fact, that was just last week on March 25, 2011?
A. I believe so. Yes.
Q. And that particular interview was tape-recorded; correct?
A. Yes.
Q. The prosecutor who in interviewed you on March 25, 2011, was named Dana Owens?
A. I don't remember the exact name.
Q. Okay. It was a female?

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A. Yes.
Q. And it was not Ms. Polk; correct?
A. No.
Q. And do you recall whether or not Mr. Hughes was present in any manner during that interview?
A. Not to my knowledge.
Q. And that interview was by telephone; correct?
A. Yes.
Q. So prior to that date, just a week ago, no one from the Yavapai County Attorney's Office, including Ms. Polk or Mr. Hughes, has ever contacted you to ask you about your observations of Ms. Neuman on the date in question?
A. Correct.
Q. I listened to the tape recording of your interview. And I noticed that there were several other people present. And so, if I may, I'm going to ask you who those people are. Okay?
A. Okay.
Q. You had someone named Vickie Lewis?
A. Yes.
Q. Who is she?
A. She is the head of risk management for

Flagstaff Medical Center, my employer.
Q. Okay. And so we're -- so we understand, you work for Guardian Air Transport. That's a division of Northern Arizona Healthcare?
A. Correct.
Q. Northern Arizona Healthcare encompasses Flagstaff Medical Center?
A. Correct.
Q. It also encompasses Verde Valley Medical Center?
A. Correct.
Q. And, to your knowledge, in addition to Ms. Neuman and other patients, there were also patients from that incident that went to Verde Valley; correct?
A. I don't know where all the patients went.
Q. Fair enough. So you had someone from risk management present for you. You also had someone named Ryan Stevens; is that correct?
A. Yes.
Q. And I've met Mr. Stevens today -- or yesterday; correct?
A. Correct.
Q. He's in court today here with you?
A. Yes.

Q. And could you tell us who he is.
A. He is a lawyer that NAH, or Flagstaff Medical Center, has hired to -- to be with me here for this interview.
Q. Okay.
A. This testimony.
Q. And Mr. Stevens is a private attorney; correct?
A. I don't know exactly what the differences are as to private versus public. I can't make a -- a statement in regards to what kind of attorney he is.
Q. Sure. Do you know whether or not Mr. Stevens is from a law firm called "McGuire Gardner"?
A. Correct.
Q. And Mr. Stevens was provided to you by your employer to be present with you during the questions that were posed by the prosecutor from Ms. Polk's office; correct?
A. Yes.
Q. And he also came with you to court yesterday?
A. Yes.
Q. As well as today?

A. Correct.
Q. And is that simply because your employer, as part of risk management, it wants to make sure that somebody is here for you?
A. That's my understanding. Yes.
Q. Okay. Now, I understand you were subpoenaed to be here by Ms. Polk's office. But let me ask you this, Mr. Swedberg: You're not here --
Well, let me ask you this: You don't see yourself as an extension of the prosecutor, do you?
A. No, ma'am.
Q. Okay. So you're here as an independent witness doing the best you can to tell this jury what you saw and heard?
A. Yes.
Q. Okay. Thank you. Have you had a chance, prior to coming in court today, to review your EMS or your run sheet?
A. I reviewed it on -- on the 25th.
Q. That's the interview?
A. Yes.
Q. Okay. Have you had a chance to review any other medical records in this case?
A. No.

Q. All right. We've made reference to your -- and I'm calling it a "run sheet." It, essentially, is your report generated from your response to the scene and transportation of Ms. Neuman?
A. Yeah. The flight record.
Q. Yes. The flight record. Thank you. We've made reference to a number of copies. And I just want to make sure we clarify this a bit.
I'm going to hand you Exhibit 369. Would you confirm that that is the flight record generated by you in connection to this incident.
A. This is a flight record that was generated by Butch Ignacio.
Q. Okay.
A. And it does not have my signature on it yet.
Q. Great. Thank you for that explanation. Does it look like Butch Ignacio, with the time and date stamp at the top, generated that document on October 8, 2009 -- let me point you up here -- at approximately 11:37 p.m.?
A. That's when it began to be generated. And she signed it at 2251.
Q. Okay.

A. So I would believe that this time stamp is when it was printed and this is when she signed it.

Q. Thank you, sir. I'm going to hand you Exhibit 791, which was marked by the prosecutor yesterday -- or spoken about yesterday. Would you confirm that that also is another copy of your flight record in connection with this incident?

A. Yes.

Q. And I'm going to hand you what was marked as -- I'm going to hand you Exhibit 792, which Mr. Hughes referred to today. And would you confirm that that also is a copy of the flight record generated by you or your company in connection to this incident?

A. Yes.

Q. Okay. So I understand, we have three copies in front of you -- Exhibit 369, 791, and 792. Could you tell the jury whether that is, essentially, a copy, triplicates, essentially, of the same record.

A. The first record doesn't have my signature. And then the next two are identical.

Q. Okay. With the exception of -- of the absence of your electronic signature on 369, it is

the same copy as 791 and 792; correct?

A. Yes.

Q. Okay. I just didn't want the jury to think that we're dealing with three different records.

You've had a chance to review your record. And I'm going to refer to Exhibit 396 because that was a copy I was provided initially. That one, sir.

Thank you?

A. 369?

Q. 369. Thank you. You've had a chance to review your flight record. And, as you said, it was on March 25, 2011, when you spoke to a prosecutor from Ms. Polk's office.

Can you tell us whether or not, based upon your review, that everything contained in that record with the exception of the 207.5 degree Fahrenheit axillary temperature that you recorded -- but everything other than that is accurate?

A. That is my understanding.

Q. And it would be accurate to the best of your ability in terms of what you observed on that day and what you recall -- recalled and recorded;

correct?

A. That's correct.

Q. Okay. Let's talk about that particular temperature. I'm going to refer you to your -- exhibit -- well, actually, let me get back to that, sir.

The axillary temperature we're speaking of, the 207.5 degree Fahrenheit, Mr. Hughes asked you and you clarified for this jury that that is not a correct temperature; correct?

A. Yes.

Q. Obviously, Ms. Neuman was not 207.5 degrees Fahrenheit that day?

A. Yes.

Q. Okay. Let me leave that, and I'll come back to it.

Referring you to Exhibit 369, sir, on the first page there are a number of times that were recorded. And I'd like to speak to you regarding these times and what, if anything, you observed at each of those hours. Okay?

A. Okay.

Q. The first time you have there is dispatch 1749. And that would be 5:49 in lay terms; correct?

A. 5:49 p.m. Yes.

Q. Okay. So at 5:49 p.m. Guardian Air received a call to respond to a scene; is that correct?

A. No.

Q. Guardian Air got a call and you were dispatched, meaning you received a call at 5:49?

A. Correct.

Q. Thank you. And when you got that call, you were told that a patient was in cardiac arrest; is that correct?

A. Yes.

Q. And when you responded to the scene, you had responsibility for the care of Ms. Neuman; correct?

A. Yes.

Q. But Ms. Neuman was not in cardiac arrest?

A. That's correct.

Q. Okay. And -- and that's not unusual, correct --

A. No.

Q. -- to have information through the dispatch that differs from information you get at the scene?

A. Correct.

Q. Okay. You indicated that the information you received through the dispatch is going to be something that is very minimal. I believe that's what you said during your interview with the prosecutor. Is that correct?
A. Oftentimes, yes.
Q. Okay. And -- as it was in this case; correct?
A. Correct.
Q. All you got was a patient in cardiac arrest; correct?
A. Correct.
Q. Which turned out not to be accurate with respect to Ms. Neuman?
A. Right.
Q. You also spoke to the jury about information you received about how long the sweat lodge ceremony went on for; correct?
A. Yes.
Q. And you noted in your report in one place that it went on for three hours?
A. Yes.
Q. And you've told the jury already -- and I just want to make sure we're on the same page -- that information is hearsay and you cannot vouch

for it's accuracy; correct?
A. Correct.
Q. The next time here is en route 1758. In lay people's language, that's 5:58 p.m.; correct?
A. Correct.
Q. Which means you lifted off from Pulliam Airport in Flagstaff at 5:58?
A. Yes.
Q. With your entire flight crew -- Don Clarke and Butch Ignacio?
A. Yes.
Q. You then responded to Angel Valley. And that's in Sedona. And the next hour, 6:15, is the time that you landed; correct?
A. Yes.
Q. And when you landed at Angel Valley, you were given directions by the incident command center as to where to land; is that correct?
A. Yes.
Q. And you actually landed some 100 yards away from the scene; is that correct?
A. Away from the patient.
Q. Okay. At some point you became aware there was a sweat lodge structure on the site; correct? On Angel Valley?

A. I -- I was told that there was one there.
Q. Okay. You yourself were never at the site of the sweat lodge structure; correct?
A. That's correct.
Q. You never saw what the structure looked like; correct?
A. Correct.
Q. You never saw any folks, if there were any, outside the sweat lodge structure; correct?
A. Correct.
Q. And that's because you were directed to land some hundred yards away from the site; correct?
A. I don't know where the site was, so I can't make a determination as to how far away from the site I landed.
Q. Okay. So when you say a hundred yards, you mean a hundred yards away from where Ms. Neuman was --
A. Correct.
Q. -- when you received her?
A. Yes.
Q. Okay. Now, in your interview with the prosecutor on March 25, you said 100 to 150. Is that more accurate?

A. I don't remember. I don't recall.
Q. Okay. Could it have been as far as 150 yards?
A. Yes.
Q. So having not ever been to the sweat lodge structure, sir, you never did put your eyes on any other folks who might have been in medical distress; correct?
A. Correct.
Q. And as you told this jury, your focus was on Liz Neuman?
A. Correct.
Q. The next hour that you have there is you were at the patient at 1817. That would be, in lay people's term, 6:17 p.m.; correct?
A. Correct.
Q. And now, as I understand, you land and Ms. Neuman is about 100 to 150 yards away from your aircraft?
A. Yes.
Q. And did you go to her or were you meeting her at some point in between that distance and your aircraft?
A. We went to her.
Q. Okay.

A. Not directly, but we went to her.
Q. And she was being brought to you by other EMS service personnel; correct?
A. Correct.
Q. And at this time you're not sure if that was the Verde Valley Fire Department or the Sedona Fire Department or some other transport?
A. Correct.
Q. Do you remember how many people were bringing Ms. Neuman to you?
A. Several.
Q. Several. By "several," you mean at least two?
A. Yes.
Q. If not more?
A. If not more.
Q. Okay. So you touched down. You see where the patient is. And you go to meet her. And that's some 100, 150 yards away?
A. Correct.
Q. When you saw Ms. Neuman, she had -- she had obvious signs of already being treated with some sort of medical intervention; correct?
A. Yes.
Q. You said she was on a C -- you called it

a "spine board"?
A. Yeah. A long spine board.
Q. A long spine board. And she was already on a gurney?
A. Yes.
Q. And that's how they were taking her to you; correct?
A. Yes.
Q. Now, you explained that the spine board is a precaution for a patient found down. So at this state you're not telling the jury that she had any spinal injury; correct?
A. Correct.
Q. In fact, she didn't, if you know?
A. I don't know what injuries she wound up having.
Q. Okay. But I just want to make sure we're clear. You're not telling the jury that because she was on a spine board that you knew or you received information that she had suffered any spinal injury?
A. That's correct.
Q. Okay. You indicated that she was also already on a peripheral I.V.; is that correct?
A. Yes.

Q. And you could tell from the bag how much -- how much fluid was going in; correct?
A. Correct.
Q. And in total you saw about -- what was it? A 800 cc bag?
A. No. It's -- 1,000 cc bag is the typical I.V. bag.
Q. I thought earlier you told Mr. Hughes that there was 800 cc and you added an additional 200?
A. There was 800 cc infused --
Q. Yes.
A. -- and then during our transport we infused 200.
Q. Okay. So what was the bag that you saw when she was being brought to you initially with the peripheral I.V.?
A. The bags are 1,000 cc.
Q. Okay. Maybe we're crossing signals here. The bag is 1,000 cc. But do you know how much, in fact, was in that bag?
A. 1,000 cc.
Q. Okay. Great. When you saw Ms. Neuman with a peripheral I.V. already started, did you receive any information from the EMS personnel who

handed her over to you as to what hour, when it was, that they started that I.V.?
A. No.
Q. Okay. So at this point you're not sure. Do you know whether or not the first 9-1-1 wall -- 9-1-1- call came out at 5:19?
A. I don't know.
Q. Okay. So at this point you're not sure how long after that 9-1-1 call was generated that that I.V. was then started with Ms. Neuman?
A. I have no knowledge.
Q. Okay. In addition to the peripheral I.V., you also saw that Ms. Neuman had had oxygen started; correct?
A. Correct.
Q. And that's with a nonrebreather mask?
A. Yes.
Q. And that obviously is to get oxygen to her?
A. Yes.
Q. And that's an appropriate procedure given someone who is down with loss of consciousness?
A. Yes.
Q. Okay. And Mr. Hughes had asked you whether anyone had given you information regarding

Ms. Neuman, her medical history, emergency ID, or contact information. You had told the prosecutor on March 25 that you believe Ms. Neuman's daughter was present?

A. No. Someone identified themselves as -- as being a family member. I don't remember what the -- what relationship they were.

Q. Okay.

A. I do remember someone saying that they were a family member there.

Q. All right. And that was a female, I assume, then?

A. Yes.

Q. Okay. And you're not sure to this date whether or not that person actually was a family member?

A. Correct.

Q. But the person, given the way you described the relationship, was someone who expressed some concern for Ms. Neuman?

A. Yes.

Q. Some care for her?

A. Yes.

Q. And did they provide you with any information when you encountered that person?

A. No.

Q. Okay. When you got to Ms. Neuman at 6:17 and you -- you took over care for her, at that instant your main job, your main goal, is to stabilize her to the best of your ability; correct?

A. To stabilize and obtain information. Yes.

Q. Okay. And that was so that could you immediately transport her out of the scene to a medical facility?

A. Correct.

Q. Okay. And during that time that you were trying to stabilize and obtain information, was Butch Ignacio next to you?

A. She was with me at the --

Q. Okay.

A. -- patient's side. Yes.

Q. And you were working as a team; correct?

A. Yes.

Q. Let me talk to you first about some of your observations of Ms. Neuman. You noted that her altered mental status was a 7 on the Glasgow Coma Scale; correct?

A. Correct.

Q. And that indicates -- the highest is 15?

A. Correct.

Q. The lowest is 3?

A. Yes.

Q. And so 7 indicates to you that she is somewhat seriously unresponsive; correct?

A. Yes.

Q. You told the jury that she wouldn't open her eyes or speak to you?

A. Yes.

Q. Okay. But you were able to at some point measure the size of her pupils; is that correct?

A. Yes.

Q. Now, you told us that you actually received Ms. Neuman from other EMS personnel who'd already attended to her; correct?

A. Yes.

Q. Let me give you Exhibit 365, which has already been admitted into evidence. And I'm going to refer you to a page that's Bates stamped 2597.

Looking at that page, sir, do you recognize that to be a field worksheet generated by Verde Valley Fire District?

A. That's what it says. Yes.

Q. Okay. And below in the personal information, do you see Liz Neuman's name?

A. If that's what the handwriting says, yes.

Q. Does that -- I don't want to have you agree with me if you don't.

A. It looks like "Neuman" to me.

Q. Okay. I have it up on the screen now, sir. And that says, Verde Valley Fire District Field Worksheet, Liz Neuman; correct?

A. Yes.

Q. Looking at this document, sir, does it appear to you to be the run sheet or the information generated by the EMS service who had Ms. Neuman before she was in your care?

A. I don't know when this run sheet was generated. And I don't know -- I've never seen it before.

Q. Okay. Well, let me ask you this: And I understand you've not seen it before. Does it look to you like -- where we see time and drugs, the first time that's in that column is 5:50?

A. On the left there?

Q. Yes.

A. Yes.

Q. Yes. On the left you see 5:50?

A. Yes.

Q. That obviously is about -- you got to

Ms. Neuman at 6:17. So this is about 17 minutes before you got to her; correct?

A. Approximately. Yes.

Q. Approximately. Do you see here under that time there's another time for 5:55 that someone from Verde Valley Fire District noted Ms. Neuman's pupils to be 2 millimeters, nonreactive?

A. Yes.

Q. And, again, that would, assuming this came from a Verde Valley Fire District personnel, be an observation made before you saw Ms. Neuman yourself?

A. Yes.

Q. You then saw Ms. Neuman at 6:17. And consistent with this observation you also noted that her eyes were constricted? Her pupils were constricted? Correct?

A. Correct.

Q. And we're now back at Exhibit 369, sir. And I'm looking at the first page. And there you noted that both the left and the right pupils were constricted; correct?

A. Correct.

Q. Now, you at some point delivered her a

dose of Naxol -- how do I say that?

A. Naloxone.

Q. Naloxone. Which is the same thing as Narcan; correct?

A. Correct.

Q. And I believe, based on your record, you delivered that dose at 6:45?

A. That's affirmative.

Q. And that would be obviously after the Verde Valley Fire District personnel observed her eyes or pupils to be 2 millimeters; correct?

A. Correct.

Q. And that would also be after you observed her pupils to be constricted.

A. Correct.

Q. So if there was a suggestion that the delivery of Narcan by you had an effect making her eyes -- her pupils pinpoint and constricted, that would not be a correct suggestion. Correct?

A. I'm sorry?

Q. That was poorly worded. Let me try it -- try it again.

You saw the Verde Valley Fire District personnel noted her pupils to be 2 millimeters. And that would have been about 5:55 p.m.; correct?

A. Yes.

Q. And that would be approximately now 17 or 12 minutes before you saw her; correct?

A. I'm sorry. There's not a time stamp across from the pupils of 2 millimeters and nonreactive on the Verde Valley Fire District record. So I -- I really can't speak to the time that they noted. I can say that it was probably noticed before I got there.

Q. Okay. That's fair. Perhaps someone from there can explain that better. But you know, based upon the fact that this was by Verde Valley Fire District, that would have been an observation made before you saw Ms. Neuman?

A. Yes.

Q. So before you saw Ms. Neuman, somebody else had seen that her pupils were pinpoint?

A. Correct.

Q. Then you noticed that she also had constricted, pinpoint pupils; correct?

A. Yes.

Q. And that was immediately upon seeing Ms. Neuman at about 6:17; correct?

A. Correct.

Q. You delivered Narcan at 6:45 p.m., which

is after -- more than half an hour after both of these observations; correct?

A. Approximately half hour after. Yes.

Q. All right. So my question to you -- and I hope this is better -- is that if there was a suggestion that Narcan is the reason why her eyes were initially pinpoint, that would not be correct?

A. Are you asking me if Narcan causes pinpoint pupils?

Q. Well, you can go ahead and answer that. Does it?

A. No.

Q. All right. So it doesn't even cause pinpoint pupils; is that right?

A. That's correct.

Q. But if there was a suggestion by somebody that it does, obviously because you delivered the Narcan almost a half hour after you saw the eyes, pupils, were pinpoint, that had nothing to do with the fact that her eyes or pupils were pinpoint; correct?

A. No.

Q. Thank you. You then noted that her skin was clammy and cold to the touch; correct?

A. Yes.

Q. It wasn't dry; correct?
A. **That's correct.**
Q. In fact, you noted her extremities were cool to the touch and slightly dusky?
Do you want me to put that up there?
A. **Please. I'm trying to find which page.**
Q. It's going to be on your -- page 2, sir.
A. **Okay.**
Q. Let me come up to you. It might be quicker.
So you did note that her extremities were cool to the touch?
A. **Yes.**
Q. And by "extremities," you meant the arms, the hands, and the legs?
A. **And feet.**
Q. And feet. And you touched all -- all those parts?
A. **Correct.**
Q. And noted them to be cool?
A. **Yes.**
Q. And you noted that she was clammy and cold?
A. **Yes.**
Q. In fact, you told the prosecutor on

March 25, 2011, during that interview, that she was not a super-hot patient; correct?
A. **I believe so.**
Q. All right. So let's move, then, into temperature. You -- you'd already told the jury and been corrected that that temperature of 207.5 degree axillary was erroneous; correct?
A. **Correct.**
Q. And axillary, you've explained to the jury, is a temperature taken from the armpit?
A. **Yes.**
Q. Mr. Hughes asked you whether or not you knew it was lower or higher, and you indicated lower?
A. **I'm sorry. Lower than?**
Q. Lower than a rectal temperature.
A. **Yes.**
Q. So let me ask you the next question. Do you know whether or not it's lower by a few degrees?
A. **I -- I can't confer that.**
Q. Okay. If a medical doctor testified that it is a few degrees lower than a rectal temperature, you would have no basis on your own to dispute that; correct?

A. **Correct.**
Q. All right. Thank you. So let's go to that temperature reading. And I'm going to now refer to -- I believe it's your second page of that run sheet -- I'm sorry. I misspoke. It's going to be the third page.
And we're looking at Exhibit 365 still -- I'm sorry. 369; right? All right. Yes.
Let me help you. Okay.
That temperature you took, sir, was taken at 6:25 p.m.; correct?
A. **Yes.**
Q. So within eight minutes of seeing Ms. Neuman, you took an axillary temperature. And it read to be below normal, 97.5 degrees; correct?
A. **Correct.**
Q. Do you recall whether or not you took more than one axillary temperature that day?
A. **I do not.**
Q. Okay. I notice that this is 97.5, and the one that we know is wrong was 207.5. Could that explain the error to you?
A. **I'm sorry. I don't understand.**
Q. Okay. What you have here is accurate -- 97.5 is accurate; correct?

A. **Correct.**
Q. The inaccurate temperature I noticed is 207.5. So the 7.5 being the same, is it possible that you meant to put 97.5 in that particular entry?
A. **No.**
Q. Okay. But we know for certain that what you took at 6:25 was below normal and was 97.5 degrees Fahrenheit?
A. **Correct.**
Q. Now, you then transported her to Flagstaff Medical Center. And upon arrival she was immediately taken into the care of the emergency room doctor and nurses; correct?
A. **Yes.**
Q. And at 6:46 they took a rectal temperature; correct?
A. **The -- on the flight record the rectal temperature is listed under 1900 hours.**
Q. Okay. We'll get to that.
A. **Which is 7:00 p.m.**
Q. We'll get to that.
Let me ask you to look at Exhibit 365. And I'm going to refer you to the Bates stamp 2600 and have you take a look at the top line.

Okay. At the top line there, sir, this is a record from the ER room at Flagstaff Medical; correct?

A. Yes.

Q. And you see the time of 6:46 p.m.?

A. Yes.

Q. And do you see a notation to the right of that of 38.7 rectal, or "R" for rectal?

A. Yes.

Q. Okay. You then also on your run sheet or your record took a recording of another rectal temperature of 38.4 degrees Celsius; correct?

A. Yes.

Q. Do you know whether or not that translates to 101.4 degrees Fahrenheit?

A. I do not.

Q. Okay. Any reason to dispute that?

A. I have no basis to make a decision.

Q. Okay. Now -- I'm almost done. And I'm going to get you out of here before lunch.

You told Mr. Hughes that based upon your training as a paramedic, you believed the signs and symptoms you saw of Ms. Neuman were consistent with heat stroke, I believe?

A. There were some signs and symptoms that were. Yes.

Q. Okay. And -- and as we spoke -- and I mean no disrespect -- you're not giving the jury a medical diagnosis?

A. No, I'm not.

Q. Okay. That's -- that's your personal opinion; correct?

A. Yes.

Q. And as you told this jury, you would certainly defer to a medical doctor who has the training and education and the background to render a medical diagnosis?

A. Yes.

Q. Since Mr. Hughes asked, let me ask you. Do you know whether or not the signs and symptoms of heat stress oftentimes mimic the signs and symptoms of organophosphate poisoning?

A. Not in my --

Q. If you don't, that's fine.

A. Not -- not in my experience.

Q. That's sort of -- again, no disrespect -- above your pay grade?

A. I wouldn't categorize it like that.

Q. Okay. Then let me take that back. It's outside the scope of your experience?

A. Yes.

Q. Outside of scope of your education and training?

A. No.

Q. Outside the scope of your experience is where you're going to put it?

A. Yes.

Q. Okay. Great. Now, if -- you told us earlier that Dr. Peterson -- and that's Dr. Mark Peterson?

A. Yes.

Q. He's the director for your company, Guardian Air?

A. Medical director.

Q. The medical director for Guardian Air?

A. Correct.

Q. So in some ways is he sort of your boss?

A. Correct.

Q. And he is the ER doctor that you turned Ms. Neuman over to when you arrived at Flagstaff Medical; correct?

A. Correct.

Q. Let me have you take a look at Exhibit 366. And I'm going to refer you to Bates stamp 3026, Mr. Swedberg, and have you look at this

line right there.

Do you recognize this to be an emergency department report generated by Dr. Mark Peterson on October 8, 2009, sir?

A. I see emergency -- I see emergency department report. I don't see Dr. Mark Peterson's name.

Q. Okay. Let me put that up on the screen, then. You see on the right Dr. Peterson?

A. There it is. Yes.

Q. And that's who we're talking about -- your boss; correct?

A. Correct.

Q. And you see the result date of being October 8, 2009?

A. Correct.

Q. And, in fact, a triage time of 6:46 p.m., the time that you arrived to the ER at Flagstaff Medical?

A. Correct.

Q. Now, you note here that -- and let me ask you this first: You would have relayed all the information you had collected at the scene and turned that over to Dr. Peterson; correct?

A. Correct.

Q. So he had the benefit of your observations of her vitals and her condition; correct?
A. **Correct.**
Q. Then he also had the benefit of seeing Ms. Neuman herself -- himself; correct?
A. **Correct.**
Q. And after getting your information and collecting information for himself, he said, it is suspected that she has had some sort of toxidrome ingestion, but otherwise this is not known.
Do you see that?
A. **Yes.**
Q. Okay. Again, what you told Mr. Hughes is not meant to override what the doctor is saying; correct?
A. **Absolutely.**
Q. In fact, if a -- do you know who Dr. Cutshall is?
A. **Cutshall? No.**
Q. Brent Cutshall?
A. **No.**
Q. Okay. You're not familiar with him as the ICU doctor who had Ms. Neuman in his care?
A. **I know a Cutsal.**

Q. Okay. That's all right. So --
A. **I don't know if it's the same person.**
Q. You know Cutsal at Flagstaff Medical?
A. **Correct.**
Q. Okay. Perhaps the same, perhaps not. But if Dr. Cutshall, who took care of Ms. Neuman in the ICU, testified that he could not rule out organophosphate poisoning, nothing you say here today is meant to override that; correct?
A. **Correct.**
Q. Thank you, sir. I have nothing further.
Thank you, Your Honor.
THE COURT: Thank you, Ms. Do.
Mr. Hughes?
MR. HUGHES: Thank you.

REDIRECT EXAMINATION

BY MR. HUGHES:

Q. Mr. Swedberg, I realize I've got about three minutes until noon. I will try and get you out of here.
Ms. Do asked about the fact that you had a -- your company sent a lawyer to -- to the courtroom with you today. Is that something that is common for your company to do when its employees testify in court?

A. **I would -- I would believe it to be. Yes.**
Q. Do you have Exhibit 365 in front of you? Let me -- let me see if I can figure it out more quickly. They put stickers on the back. I'm going to take that away from you for just a moment and ask a question.
Ms. Do asked you some questions about a fire department form. Do you recall being asked about this?
A. **Yes.**
Q. And I realize it's not your form, but since you got asked about it, I'm going to ask you if you know what the blood pressure, or BP, readings indicate.
A. **So the reading I can do of it is 80 over 50. There's a line drawn through 22 and a line drawn through 33.**
Q. Okay. And you had mentioned, and I think it's in your report, that Ms. Neuman was hypotensive or had low blood pressure?
A. **Yes.**
Q. And that was something that the fire department had told you?
A. **Correct.**

Q. Was that reading of 80 over 50 consistent with someone who is hypotensive or has low blood pressure?
A. **Yes.**
Q. How about the next reading, 88 over 50?
A. **The same.**
Q. And do you know at what point the fire department started to provide her with the I.V.?
A. **I think that there's a time associated with this report just off the screen. And that would be able to provide that answer.**
Q. And can you tell me whereabouts on the document.
A. **So just to -- right there. At 5:55 they have an I.V. listed.**
Q. Would that be approximately, then, the time when the blood pressure went from 88 over 50 to 104 over 45?
A. **Yes.**
Q. Okay. Ms. Do asked some questions about the difference in signs and -- common signs and symptoms for heat stroke as opposed to what you'd expect for organophosphate poisoning. Can you tell me what your understanding is of the difference of the signs and symptoms for those two disorders.

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A. Signs and symptoms that I look for in -- in heat stroke are rapid respirations; tachycardia; low blood pressure; hot skin; red skin that is dry, that is no longer sweating.

Q. Are you looking at -- for those -- the temperature of the skin if you come to a scene an hour or so after the person has been exposed to heat?

A. At that point I wouldn't make a determine -- I wouldn't be able to accurately make a determination as to the patient's skin condition.

Q. And can you tell us what the different signs and symptoms, then, that you'd expect to see for organophosphate poisoning?

MS. DO: Your Honor, objection. Foundation.

THE COURT: Overruled.

THE WITNESS: So organophosphate poisoning, to the best of my memory, I look for the mad as a hatter. That means altered mental status where the patient just displays being not within their normal behavior. Their skin would be very red. There would be a lot of mucus.

And depending on the severity and the time from when exposure began to my viewing of the patient, how much mucus would be produced and the

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progression of symptoms, such as tachycardia or rapid respirations.

Q. BY MR. HUGHES: And do you have Exhibit 366 up here, the one with the Dr. Peterson report that Ms. Do asked you about?

A. Right there.

Q. And, sir, do you remember, is this the report that Ms. Do asked you about?

A. Yes.

Q. Did she ask you about if that's -- if this is the start of the report, did she ask you about the end of the report --

A. No, she did not.

Q. The diagnosis? Including consider heat stroke or heart-related injury?

A. Okay. I see that.

MS. DO: Your Honor, under Rule 106, I ask that we read the sentence of No. 5.

THE COURT: It's -- it's apparent on the screen there.

MS. DO: Thank you.

Q. BY MR. HUGHES: In fact, do you know whether an endotracheal intubation occurred once Ms. Neuman was brought to the hospital?

A. Yes.

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Q. And I think we asked you some questions about that. But is that the procedure that's documented on the final page of your report at the 1900 time?

A. Yes.

Q. Thank you, Mr. Swedberg. I appreciate you being patient with me.

THE COURT: Thank you, Mr. Hughes.

Ladies and gentlemen, do any of you have a question for this witness?

I guess not.

Then may Mr. Swedberg be excused as a witness at this time?

MR. HUGHES: Yes, Your Honor.

MS. DO: Yes, Your Honor.

THE COURT: Sir, you will be excused as a witness in just a moment. I'll excuse the jury as well for the noon recess. Please remember the rule of exclusion of witnesses that we discussed beforehand.

You would be permitted to stay in the courtroom now if you wished. But you cannot in any way, communicate or attempt to communicate with any other witness until the trial is completed.

Do you understand that?

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THE WITNESS: Yes.

THE COURT: Okay. Thank you.

Ladies and gentlemen, we will take the noon recess. The usual time. Please be reassembled at 1:30, and we'll start as soon as we can after that. Remember the admonition. We are in recess.

Thank you.

(Recess.)

THE COURT: The record will show the presence of the defendant, Mr. Ray; the attorneys, and the jury.

And the state may call the next witness.

MR. HUGHES: Thank you, Your Honor.

The state calls Dustin Chambliss.

THE COURT: Sir, if you could please step to the front of the courtroom where the bailiff is directing you.

Raise you're right hand and be sworn by the clerk, please.

DUSTIN A. CHAMBLISS,

having been first duly sworn upon his oath to tell the truth, the whole truth, and nothing but the truth, testified as follows:

THE COURT: Please be seated here at the

witness stand.
Sir, would you please start by stating and spelling your full name.
THE WITNESS: Dustin Andrew Chambliss; D-u-s-t-i-n, A-n-d-r-e-w, C-h-a-m-b-l-i-s-s.
THE COURT: Thank you.
Mr. Hughes.
MR. HUGHES: Thank you.
DIRECT EXAMINATION
BY MR. HUGHES:
Q. Sir, can you tell us what you do for a living.
A. I'm an engineer-paramedic with Verde Valley Fire District.
Q. And what is an engineer-paramedic?
A. Engineer is the driver responsible for the fire apparatus. And paramedic is just taking care of the -- the advanced life support for our community.
Q. And how long have you been a paramedic?
A. Since December of 2001.
Q. And do you have any prior medical training or experience prior to becoming a paramedic in 2001?
A. Yeah. I received my certificate for EMT,

emergency medical technician, the basic level, in 1997.
Q. And after you received your EMT certificate in 1997, do you know what year, then, you began as a paramedic?
A. In 2001.
Q. 2001. Okay. And can you tell us briefly what sort of training you had to have to first become an EMT and then to become a paramedic.
A. The EMT course is a semester long through the community college and then minimum of one year's service as an EMT before you can take the paramedic curriculum. And at that time the paramedic curriculum was a 12-month class.
Q. And was that through Yavapai College?
A. Through Yavapai College and Northern Arizona Healthcare.
Q. Apart from -- can you tell us where you worked as an EMT or paramedic or volunteered as an EMT or paramedic.
A. For Verde Valley Fire. I've also been working with Verde Valley Ambulance Company in the city of Cottonwood since 1998. Started out as an EMT and up to -- then when I got my paramedic. And then I also worked as a paramedic for Blue Ridge

Fire for about the last year and a half.
Q. Do you recall an incident back in 2009 where you treated a woman by the name of Kirby Brown?
A. Yes.
Q. And can you tell us in general what do you recall about that incident?
A. We were dispatched to two full codes in progress, two -- to people having CPR done on them as we were responding in. We arrived there, and there were two people having CPR done on them. I took care of one patient. My partner took care of the other and went from there.
Q. And who was your partner?
A. Greg Vanderhaar.
Q. And did you prepare a report in connection with treating the patient?
A. Yeah. A patient care report.
MR. HUGHES: Your Honor, the state would move the admission of Exhibit 374.
MR. LI: No objection, Your Honor.
THE COURT: 374 is admitted.
(Exhibit 374 admitted.)
MR. HUGHES: And may I approach the witness, Your Honor?

THE COURT: Yes.
Q. BY MR. HUGHES: Sir, I'm going to show you what's admitted as Exhibit 374 and ask if you recognize that document.
A. Yes. That's my patient care report.
Q. And can you tell us how it is or what the purpose is behind a patient -- preparing a patient care report.
A. What's the purpose of --
Q. Why would you prepare a report?
A. It's a written document of the care of the patient that we did from the time we had them from the scene of the call to the time that we get them and transfer them to the emergency room physician.
Q. And do you know whether a copy of your report is provided to the emergency room physicians?
A. Yes.
Q. And that was a bad question. I asked if you knew if one was provided.
A. Okay.
Q. Was a copy of the report provided to the emergency room physician?
A. Yes.

Q. Okay. I'm going to show you your report and ask if you can explain what some of the references are on this report so we can understand what the different language and verbiage is on this report.

To start out with, can you tell us, if you would, what this information up here in that area is referring to on the upper left corner of the report.

A. That 9-1-1 dispatch code?

Q. Yeah.

A. Is that what you're referring to?

Q. What's a 9-1-1 dispatch code?

A. That is when the call was received at the dispatch center. They told us that we were to respond Code 3, which is lights and sirens.

Q. And then what does the to hospital code stand for?

A. That just verifies that we went to the hospital with lights and sirens.

Q. Okay. And then turning to the other side of the top of the page, it says, ER. Do you know what that stands for?

A. Oh. That was my reference of which page I gave to the emergency room. We have to have a

report for the emergency room. We have to take one back to the fire district. And then one goes for our RQ at the ER. So there's three copies of the report that are made.

Q. And did you, then, write the initials "ER" at the top of the page?

A. Yes, sir.

Q. And what -- what "then" does that signify to you?

A. Well, I had three piles of paperwork. And that was the pile of the paperwork that was to be delivered to the ER -- or the emergency room physician.

Q. And then underneath that there's some mileage. What -- what's the -- the significance, if any, of the mileage on your report?

A. That just keeps track of how many miles it took us to get from the scene to the hospital for billing purposes.

Q. And then underneath that section we have this information sort of in the top. I'm going to just ask you to start working your way down. But if you can go from left to right and tell us what that information indicates as far as year, incident number, and so on on the report.

A. The year was '09, 2009. The incident number was the number of calls that our fire district had responded to up to that point. The residence box or the RES box determines whether it's a tax-paying resident in our district or not. And she was not.

The patient numbers. She was patient No. 1 per the commanding officer that was there. And the second box that was left blank was because at the time we didn't know exactly how many patients were going to be transported at that time.

The VVFD is the abbreviation for Verde Valley Fire District. And then paramedic unit responding was Engine 311 or E311.

Q. Is that the vehicle that you -- you rode there in?

A. Yes.

Q. And can you tell us what the remainder of that information and that top line signifies.

A. Shift was C, which is the -- the shift that I'm on. We have an A, B, C shift. The date and the month. The transporting unit that I was in. I was in the back of ambulance 311 as the paramedic.

The 1109 is what they call an EMS com

number, which is an emergency number that's given by the state to -- you know -- keep record of each individual ambulance. And then the unit providing care was, again, ambulance 311.

Q. Okay. And then moving down, then, can you explain what the next line -- or date entered on the next line refers to.

A. The address was the address of the facility at Angel Valley or the grounds out there. That's the address given.

Q. Where did you get that address from?

A. The dispatch information.

Q. And can you tell us where were you when you first were dispatched to -- to the scene?

A. At Station 31 in Cottonwood.

Q. And how does the dispatch work? How -- how do you go from being at the station to getting in your rig and going somewhere?

A. The department is issued phone pagers or communication pagers that we wear on our belts when we're on duty at the station -- which go off just like -- kind of like a text message. And also there's an audible alarm and a -- a light alarm that goes off at the -- at the station when there's a call.

Q. And then medic EMT data number. What does that stand for?
A. That's my paramedic number. The "P" indicates paramedic. And then the 56754 is the number that the State issued me when I received my paramedic certification.
Q. And then what does "ATT" stand for?
A. Attended. So in other words, I was the one attending the patient in the back of the ambulance.
Q. And then next to that there's a blank box, medic/EMT data number. Can you tell us what that box would signify if it had been filled in.
A. Number of people that were -- were hands on with the patient. So the boxes just below mine, box No. 2 and 3, were just the other paramedics that were on scene.
Q. And so there are three different numbers that are indicated. Does that indicate that there were, including yourself, three paramedics working or -- or medics or EMTs working on that same patient?
A. I wrote in there that there was myself, one other paramedic, and then an EMT, which is the "B." The "B" stands for basic.

Q. And if there had been four, five, or six, would you expect, then, these boxes to have been filled out?
A. Yes, sir.
Q. Okay. And can you explain what the significance is that for these two boxes here there's no check mark in the ATT box.
A. We normally only use the charge medic or the person that's attending the patient in the back of the -- in the back of the ambulance while it's en route to the hospital. So had there been more paramedics or EMTs in the back of the ambulance with me, they would have that box marked as attendants also.
Q. Was one or the other of the other people driving the ambulance, then?
A. Yeah. The -- the B74637 was the driver.
Q. And then turning then to the next line, can you tell us what the service type -- and you've marked "ALS" -- stands for.
A. Advanced life support.
Q. And what does that signify?
A. The difference between basic life support and advanced life support is -- you know -- starting IV lines, or intravenous lines, giving

medications to patients. Just advance skills.
Q. And then there's some boxes that are left blank. 901H. What would that signify if it had been checked?
A. Obvious death or dismemberment.
Q. And then DNR?
A. That's a do-not-resuscitate order.
Q. And then it says refusal and delay. And those are blank also. What would those signify?
A. Signed refusal would be if the patient was -- had called 9-1-1 and wanted to be evaluated but didn't want to be transported to the hospital by ambulance. They have to sign a refusal document that clears us from the scene.
And the delay box is supposed to be marked if we're on scene longer than 20 minutes. So there was no delay on that call for -- for my patient.
Q. And then underneath service type there's a name. And it says, VVMC Doe. What does that signify?
A. That's Verde Valley Medical Center's "Doe" information.
Q. At the time you arrived to treat Ms. Brown, did you know her name?

A. No, sir.
Q. At what point did you learn her name?
A. Days after the call.
Q. How about the information to the right of Doe. What does that signify?
A. That's a FIN number, which is issued through Verde Valley Medical Center.
Q. What's a FIN number?
A. Their identification number for the patients at VVMC.
Q. So it's not a number that -- that you use in your work with the patient?
A. That's their tracking system at Verde Valley Medical Center.
Q. Okay. And then over to the right it says, age, and then, sex, and then, WT. Can you tell us what that signifies? And I'm -- I'm referring to these measurements to the top of that line.
A. Patient's age was unknown at the time. We knew that she was female. The weight is an estimate in kilograms. So we estimated her weight at 55 kilograms. And then the date of birth was unknown.
Q. And then underneath it there's address

unknown. And you can't really see in this copy, but do you know what's in the shaded area underneath the address?

A. Medical history.

Q. Okay. And can you walk us through, then -- I don't see any of the boxes checked. Can you tell us what that signifies, either if something had been checked or the fact that it wasn't checked?

A. The -- the reason that it's marked as unknown is because the patient was unable to give any information. So we didn't have any kind of information on any of her past medical issues. And nobody at the scene knew anything about her at that point in time. So everything was marked as unknown.

Q. And as for as unknown, are you referring to this marking right there?

A. Yes.

Q. Okay. This mark -- this marking of unknown above that -- what does that signify?

A. Patient's address.

Q. Okay. And then there's another shaded box here, which you can't really see what's in the shaded area. Do you know what -- what that line or

those boxes are supposed to tell us?

A. Medications.

Q. And does the "UNK" -- what does that stand for?

A. Unknown.

Q. Okay. And moving, then, to the other side of the document, we've got information in that area. Can you tell us what's signified in that -- in that area going from the times and working your way down?

A. In the first column at 1742, which was the time that I had first contact with the patient, the BP, or blood pressure, was -- there was none. She was 0 over 0. The figure that's circled was just meant that the patient was supine or laying flat on her back. She had no pulse other than what was being done by bystanders' CPR.

Respirations were bystander respirations. Her skin was warm to the touch. Her capillary refill was greater than 2. Pupils were nonreactive to light. Her Glasgow Coma Scale, or the GCS, was 3. And her oxygen saturation was unknown.

Q. And we've had some of these terms explained before. But with respect to the Glasgow Coma Scale, can you explain what that scale runs

from as far as the low number to the high number.

A. It runs 3 through 15. And there's three different categories. One category is eye response. You know -- is there eye -- eye function spontaneous -- you know are they blinking, looking at you.

Then the next category is their verbal response. You know, are they allowed to converse like you and I are in appropriate sounds or words.

And then the last one is motor function. You know, are they able to feel or touch or respond when -- you know -- to either painful stimuli or whatnot.

So 15 being a normal person with all normal functions, 3 being -- you get one per category even if you have nothing.

Q. If you were to assess a Glasgow Coma Scale in someone who was deceased, what number would you -- would you assess?

A. A 3.

Q. And then up above there are some other times and abbreviations in this area. Can you tell us what those signify.

A. The dispatch time, which is 1721, is when we received the -- the call from our dispatching

center. The en route time, 1722, is the amount of time it took us from when we were told we had a call to when we were in the truck and responding.

1740 is what time we arrived on the scene. 1756 is when I was in the back of the ambulance and we left the scene to go to the hospital. 1810 is when we arrived at the hospital. And the last number you drew through, I believe, is 1837.

Q. I'm going to take that off. Sorry.

A. 1837 is when the ambulance was placed back in service.

Q. And do you recall where you were located, then, when you were dispatched to go to the scene?

A. At Station 31.

Q. And how far would you reckon Station 31 was from this address indicated here at Angel Valley Road?

A. I'm not sure of the exact mileage.

Q. Okay. Continuing, then, down there are some shaded boxes to the left of that line. Can you tell me if you recall what would be in those shaded boxes if -- if we had a better photocopy.

A. Allergies to medications is the first one. And that was also unknown. And then her

local doctor -- or her primary doctor.

Q. And then what would be in the final shaded box?

A. The patient's chief complaint.

Q. And what is a chief complaint?

A. In other words, what the patient tells you is wrong with them, why they -- why you were called.

Q. And were you able to actually talk to Ms. Brown?

A. No. She was pulseless and apneic upon arrival.

Q. And in that case how would you determine her chief complaint?

A. That she was in cardiac arrest, that she was -- had no pulse and she was not breathing.

Q. So turning, then, to the scene, can you tell us what you saw as you arrived on that scene apparently around 1740.

A. We were directed in by one of the bystanders that showed us where to go. When we arrived they said that there was two people who were having CPR done on them. They were to the left of the structure that was out there on the ground covered up with a towel. Their waist was

covered up with a towel, and they were having CPR done on them.

The first patient that I went up to, not knowing whether it was male or female, and just started taking information and finding out what was going on and how long she'd been down and if anybody else had any kind of information other than they were doing CPR from the time that -- that they called to the time that we got there.

Q. Is that what the bystander told you?

A. Uh-huh.

Q. And was that a -- the court reporter needs to know. Is that yes or no?

A. Yes.

Q. And you mentioned they -- that you started to treat a female patient. Do you recall the gender of the patient -- the other patient who was receiving CPR?

A. No.

Q. And do you recall if the CPR was being performed by bystanders or by professional EMS rescuers?

A. They were bystanders.

Q. You mentioned this was to the left of a structure. Do you remember what the structure

looked like?

A. It was kind of like a blue or a green dome-looking structure, four or five feet tall.

Q. And can you tell us, then, what you began to do once you came up upon this woman getting the CPR.

A. We asked that the bystanders continue to do CPR while we readied some of our equipment. And once we got everything ready, then we transferred from -- we had them stop and we took over.

Q. And were you able to assess vitals, then, at that time?

A. Yes. That's when she -- we determined that she had no pulse, was not breathing.

Q. And are those the vitals, then, that are referenced to the bottom of this line?

A. At 1742.

Q. Okay. And what happened or what did you do after you assessed those vitals?

A. We -- we began to place her on the AutoPulse and began advanced life support.

Q. And what is an AutoPulse?

A. It's a device that was designed to perform chest compressions on a patient so that you don't have a -- a person doing it. It does -- you

know -- adequate depth and -- and rate of compressions for a person.

Q. Is it sort of like a robotic CPR machine?

A. Kind of. Yeah.

Q. Now, when you first come up upon a patient, are you keeping the mnemonic A, B, Cs in mind?

A. Yes.

Q. And can you tell us what that stands for.

A. Airway, breathing, and circulation.

Q. And is that something that you kept in mind when you came up upon Ms. Brown?

A. Yes.

Q. And would you tell us, then, what -- what you do to -- to comply with or to look after the A, B, Cs of a patient?

A. Placing her on the AutoPulse, gave her the compressions, the airway and the breathing with our -- our CCR protocol is you get -- make sure they have a patent airway and is put on high-flow oxygen.

Q. And how do you make sure they have a patent airway?

A. By inserting an oropharyngeal airway.

Q. And did you actually insert an OPA, or an

oropharyngeal airway, in this case?
A. I believe that the basic EMT that was with me did. I did not.
Q. Did you have an opportunity when you first came upon Ms. Brown, then, to look at her mouth to assess her airway?
A. She was having ventilations given to her by bystander CPR.
Q. At some point when you and your partners took over, were you able to take a look at her mouth?
A. I didn't look in her mouth. No. We just inserted the OPA and put the oxygen on her.
Q. Did you see any obvious foaming at the mouth at that point?
A. No.
Q. And is that something if you had seen you would have reported in your report?
A. Yes.
Q. Your -- I think you've walked through a lot of this. But you have a description to the right of that line of a number of events. And I wanted to ask you what the CCR protocols -- what is -- and I don't need to know what the protocols are. But can you tell us what a CCR protocol is?

A. A CCR stands for a continuous compression resuscitation and is -- I don't want to say replacing CPR. But for us in our area it's a protocol that they're trying out. It just means you do more compressions to circulate the oxygen that's already in the patient's body versus stopping compressions to give a -- a breath and then starting compressions up. You want to build up a pressure to where it will actually circulate the oxygen that's in the blood.
Q. Okay. And then on the final line it explains -- well, can you tell us what that explains starting with -- starting with the bottom line there.
A. At which point?
Q. In other words, you mentioned the patient was placed on the AutoPulse and CCR protocols were started, and then it goes on to say, two I.V.s, O2. Tell us what that means.
A. The two I.V.s, she had two intravenous lines put in, one on each of her arms. The O2 is oxygen via nonrebreather mask. And the LP12 combipads placed. That's a LIFEPAK 12, which is our cardiac monitor that we use. And the combination pads are what's used to deliver a shock if there's a shockable rhythm.

Q. And do those pads, then, do they hook up to some sort of a machine or device that can show you whether there's any electrical rhythm in the heart?
A. Yeah. That's the LIFEPAK 12.
Q. And did you actually review the readout as -- after those were hooked up on her?
A. Yes. And she was asystolic.
Q. And can you tell us what "asystolic" means?
A. That means that there's no electrical activity in the heart.
Q. If a patient is asystolic, are you able to at -- to at least monitor to determine that using those -- those pads and the device?
A. You can. We normally use a four lead to get a better reading and three different pictures of the heart.
Q. And did you do that in this case?
A. Yes.
Q. And what did that four lead tell you as far as whether or not Ms. Brown was asystolic?
A. That she was asystolic in two or more consecutive leads.

Q. Above that description that indicates cardiac arrest, pulseless, and apneic. Can you tell us what "apneic" means?
A. Not breathing.
Q. And then over here to the right of that line there are a number of shaded boxes again. Can you tell us what -- what would be written in -- in that shading?
A. The first box that says, none, is what the patient states that their pain level is if they're able to state one. She was pulseless and apneic, but she wasn't able to tell me that she had any pain. So I wrote in, none.
The other "no" boxes that are all down there, one is -- you know -- was there a seat belt that was worn if it was a car crash. One was did the air bag go or be deployed. And the other one is was she wearing a helmet if it was in a vehicle crash.
Q. And then I think there is a fourth box. Do you recall what the fourth box would be?
A. Yeah. It states, near syncope, which means did she have a fainting episode, which she didn't -- or she might have prior but her end result was being pulseless and apneic.

Q. And you mentioned syncope. What does syncope signify?
A. Fainting.
Q. And then continuing to move down the report, there are some more shaded boxes to the right of that line. Can you tell me what would be in those shaded boxes.
A. The first one is the patient's LOC, or level of consciousness. The form says awake, alert to person, place, time, or events. And those were all no. She wasn't awake. She wasn't alert. And I couldn't -- you know -- get a person, place, time, or event from her because she was pulseless and apneic.
Q. And then this final shaded box over here, which has the "Y" next to it -- what does that signify?
A. Loss of consciousness.
Q. And then can you tell us what would be in that shaded box above the line.
A. That I think is just -- I'm not actually positive on that because it's shaded. I'm sorry.
Q. Okay. That's fine.
A. The one right above is patient's mental status. And there wasn't one. She was

unresponsive, pulseless and apneic.
Q. And then over here there's a temperature, and it indicates unknown. Did you ever attempt to obtain a temperature from Ms. Brown?
A. No.
Q. And can you tell us why not.
A. We were more worried about her airway, breathing and circulation than what her body temperature was at that time.
Q. And then down below that we've got some more shaded boxes. Can you tell us what the first shaded box would say.
A. That says, head and neck. And it's, basically, just kind of breaks down the body as the boxes go down. So the head and neck -- her lips were cyanotic or blue and that there was no trauma noted. There was no significant -- you know -- bleeding or bruising, swelling, discolorations, other than the cyanosis around the lips.
Q. And based in your experience, would cyanotic lips be consistent with a person who had been down and receiving CPR for some period of time?
A. It's due to a lack of oxygen.
Q. Do you know what the -- the next line,

shaded boxes next to the "no JVD"?
A. That is for the neck.
Q. And what does the responses to the right, then, no JVD, and so on indicate?
A. JVD is jugular vein distention. A lot of times people that are having -- you know -- cardiac issues, the blood will back up in the jugular vein, and they get distended. And she didn't have that at that time.
The tracheal deviation. That means that the trachea would be off to one side due to, like, a collapsed lung or something, which she didn't have at that time. And that there was no trauma noted to the neck. Same thing. No swelling or bleeding or bruising.
Q. And then can you tell us what the final line to the right of that purple line, what would be in that shaded area.
A. The patient's chest area.
Q. And then I think the answer to that speaks for itself. Were you able to observe how the bystanders were performing CPR?
A. Briefly. They were counting out one through 30.
Q. Did it appear that effective CPR was

being performed?
A. It did. Yes.
Q. And then underneath there's some more shaded boxes. Can you tell us what -- what those boxes say and what the responses mean to those boxes?
A. The first one is the lungs. And she was being given breath when we arrived by bystanders. The next one down I want to say is the abdomen. The one below that would be the pelvis. The one below that would be the extremities, arms and legs. And then the final box just below that would be the back. And all those, there was nothing noted as far as trauma.
Q. Okay. And then moving down, can you tell us what -- first of all, what is denoted in this column that I've -- that I've circled?
A. Those are the skills performed by the providers.
Q. Okay. And what do these numbers, then, indicate in these boxes?
A. Well, they -- they correspond with the lines that go left to right. So the B74637 states that at 1744 he had the patient on a nonrebreather mask at 15 liters.

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Q. And is that B74637 -- is that that number or the serial number for the EMT that you mentioned earlier?
A. Yeah. That's the certification number.
Q. And then beneath that there's a P56754. Is that serial number for yourself or one of the other paramedics?
A. That's my certification number.
Q. And then to the right of those numbers, what -- what do those times signify?
A. The approximate time that those skills were performed.
Q. And then can you tell us what is designated or what is signified to the right of the time of 1744.
A. I.V.s. There was two started. The solution that was used was NS. That's normal saline. The milliliters were there were two bags, a thousand liters per bag. The gauges used for the I.V. catheters was 18. The sites that were used to start the I.V.s were the right antecubital and the left antecubital, which is in the elbow area. The attempts to start the I.V. was two, one each. And was the I.V. still intact when we arrived at the hospital. And yes.

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Q. And above that there's -- in this line above the pink line there's some information. Can you tell us what that is indicating.
A. That's if someone had trauma to the neck or back. For spine stabilization.
Q. Did you note any spinal trauma in this case?
A. No.
Q. And did you put Ms. Brown on a -- on a long spine board?
A. We put her on the AutoPulse. And then to move her across the grounds, she was put on a backboard just for support, not for immobilization.
Q. And then can you tell us what this top line starting with 02 and going over to the right, what, if anything, is signified by that.
A. That's just the oxygen as far as the liters per minute that was used and what type of device was used for her. And the nonrebreather mask at 15 was marked.
Q. And what is a nonrebreather mask?
A. It's a mask that goes over the nose and mouth and provide oxygen to the patient.
Q. What does 15 signify?
A. The liters per minute that the oxygen is flowing at.

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Q. Okay. And then moving down, there's the time of 1743 and some information to the right of that. Can you tell us what that signifies.
A. 1743 is when the patient was placed on the LIFEPAK 12 cardiac monitor. The rate was zero because she didn't have a heartbeat. And then as you go across where it says, other, the patient was in asystole in three leads.
Q. And what does the asystole in three leads signify?
A. The LIFEPAK 12 can look at the heart from several different angles. And the standard leads that we use, leads 1, 2, and 3, that take the different pictures of the heart, had all shown asystole or no electrical activity.
Q. Okay. And then below that there's a time of 1747 and a pretty big box. Can you tell us what is signified or what happened at 1747.
A. That's when the advanced life support started as far as getting the I.V. set up, getting her on the AutoPulse, giving her the epinephrine medications, and getting her loaded into the ambulance for transport to the hospital.
Q. And what is epinephrine medications?

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A. It's a medicine that's supposed to help increase the -- the heart rhythm if there is one.
Q. Is that something that you would typically give a patient you find asystole?
A. Yes.
Q. And can you explain, then, what the gave EPI 1.0 mg IVP stands for.
A. That's given EPI, which is abbreviated for epinephrine. 1.0 milligrams is the cardiac dose for a full code. And the IVP is the intervenous push. In other words, we gave the drug through the I.V. line.
Q. And did you see any change in the patient's signs and symptoms after you gave the epinephrine?
A. No change.
Q. Patient was loaded into -- and A311 is your ambulance?
A. Yes, sir.
Q. And what does the patient had an OPA inserted? The NRB was rechecked?
A. That means that the patient had the oropharyngeal airway placed in her mouth. And then the nonrebreather mask was put back on and it was rechecked to make sure that it was still in place

when we transferred her from the ground to the ambulance.

Q. And can you tell us what the purpose is of inserting an -- an OPA.

A. It keeps the tongue off the back of the throat so that they can have a patent airway so the air is able to move in and out.

Q. Is an OPA the same thing as being intubated?

A. No.

Q. Can you tell us what the difference is.

A. An OPA just holds the back of the tongue up off the -- or holds the tongue up off the back of the throat. And being intubated means that a tube is passed all the way through the vocal cords into the trachea.

Q. And then it says, the patient alignment on the AutoPulse was rechecked and patient was still in asystole. Can you tell me what that stands for.

A. The patient was placed on AutoPulse. And there's a few straps to make sure that the patient is aligned properly so that the device works accurately. And anytime you move a patient on any kind of device, you have to recheck it once they're

moved to make sure that the device was still in place and working properly. And then we rechecked her heart rhythm. Again it was still asystolic.

Q. Okay. Then it -- it goes on in the next line that CCR continued with the AutoPulse. What does -- what does that mean?

A. That just means that the continuous compression resuscitation was being done with the AutoPulse.

Q. And what -- what does -- continuous compression resuscitation. What is that doing to the body?

A. It's compressing the chest so that the blood will pump through the heart just like with CPR. And all it's designed to do is to compress the heart at a hundred times a minute to keep up enough pressure to circulate the oxygen in the bloodstream.

Q. And will it also circulate, then, the I.V. fluids that are pushing into the patient?

A. Yes.

Q. In this case you indicated that there were two I.V.s?

A. Yes.

Q. And milliliters were 2,000. Was -- can

you tell us, was that two 1,000 milliliter bags?

A. Yes. One per arm.

Q. Going back down, then, after continue with AutoPulse, P56754, that's you?

A. Uh-huh.

Q. Gave second dose of EPI. Tell us what that means.

A. In the CCR protocol we're supposed to give it twice.

Q. Did you see any obvious change in the patient after the second dose?

A. No change.

Q. And then after that it says, the patient began to have blood come from the mouth, and suction was started. What did you see?

A. Blood coming from the patient's mouth.

Q. Have you seen patients who had -- at this point it's 1743; correct? Where -- I'm sorry. 1747 approximately.

A. That's when the ACLS stuff was started. So this is a time line going all the way through transport to the hospital.

Q. And do you have any idea when you first saw blood starting to come from the mouth?

A. It was when we were en route to the

hospital.

Q. Was that after the OPA had been in inserted?

A. Yes.

Q. Okay. Now, the -- the blood that you saw -- have you seen other patients who have received CPR for 40 minutes or so?

A. No.

Q. Have you seen patients begin to bleed after receiving a lengthy period of CPR?

A. Not in my career.

Q. And did you have -- the bleeding from the mouth. Did that indicate a sign or symptom that you were concerned about?

A. I was concerned to keep the blood out of her airway.

Q. And I believe it indicates that approximately a hundred cubic centimeters was suctioned?

A. Yes.

Q. You indicate there's no change in the patient's status during transport. Can you tell us what you meant by that.

A. No change in the patient's status during transport means that she never regained a heart

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rate of her own or started breathing on her own. There was no change. She was asystolic the whole time.

Q. And then underneath at 1800, do you know what's in the shaded box to the right?

A. That's when I made a -- a patch is what it -- that says in there. And that's what I patched to the hospital to let them know that we were en route with a patient that was a full code.

Q. And what does it mean for an EMS unit to patch to the hospital?

A. That gives the -- the hospital a heads up to let them know that we're coming with a patient and what we've either done for the patient or if we have to request any further orders.

Q. And with respect to the orders, can you tell us what -- what it signified after -- after the orders.

A. Just that I had advised VVMC that I was working a full code and that CPR was started at approximately 1719 by bystanders.

Q. And where did you come by that time of 1719?

A. That was on the dispatch paperwork that we get from our dispatching agency.

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Q. Would that, then, have been information that may have been relayed to dispatch by the bystanders?

A. Yes.

Q. Then underneath can you tell us what would be in these two shaded boxes at the bottom of the line here.

A. The large shaded box to the left is who I patched to at the hospital and what hospital I patched in to.

Q. And by that do you -- do you know -- do you know what hospital you patched to or what person you spoke to at the hospital?

A. I spoke to Karen at Verde Valley Medical Center.

Q. And is that done -- I guess these days it might be done using a cell phone. Or is it done with a radio?

A. It can be done either way. But cell phone is what I used.

Q. Okay. And then what is in the box to the right here?

A. That's the transfer of care to the ER nurse, which was also Karen. And that just states -- you know -- who I gave the patient to.

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And she was the charge nurse that signed -- signed my care form.

Q. And then there's a -- a box above -- that's shaded above that line. Can you tell me what would be in that box.

A. Status at the hospital. And there -- there was no change.

Q. And then down here there's some information above that line. Can you tell us what -- what that signifies.

A. That's if we did a blood draw in the field, which we didn't do; and if there was an AED that was used, which we didn't; and then if we actually defibrillated somebody, which we didn't.

Q. And why is it that you did not defibrillate or use AED?

A. Because she was in asystole and our monitor -- you can't shock asystole.

Q. If the epinephrine that you had given had had an effect, can that put a patient into systole?

A. I can't answer that question.

Q. Have you seen that happen before?

A. No.

Q. Do you know what the purpose is of giving the epinephrine?

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A. To stimulate activity in the heart.

Q. Couple more questions for you, Mr. Chambliss.

You mentioned above that the cap refill was greater than 2. Can you tell us what you mean by that?

A. That's the -- we -- it's kind of hard to explain. When we press on the fingers or -- to see how fast the blood refills into the tissues. And average of two seconds is normal for -- for everybody. And hers was greater than 2 seconds. In other words, if you pushed on her finger and compressed the blood out of her tissue and then let it go, two seconds ours would turn red again. Hers just stayed white.

Q. Would you expect a patient with no blood pressure and no pulse to have a normal capillary refill time?

A. No. Because there's no blood being circulated.

Q. You mentioned skin was warm, can you quantify that as for as how warm it felt.

A. Normal.

Q. And do you know whether when you arrived at the patient -- you arrived on scene around 1740.

Do you know whether prior to your arrival any efforts had been made to cool down the patient?

A. No, I don't.

Q. Do you know whether any efforts were made to -- to wet her down?

A. No, I don't.

Q. You mentioned that there was a -- a towel covering her -- her, for want of a better word, kind of her lower region?

A. Her waist.

Q. Okay. And can you tell us whether you noticed anything else about the patient at that time when you were there on the scene?

A. She wasn't clothed. She just had the towel over her waist.

Q. Do you know whether her skin was wet or dry at the time you got there?

A. I believe it was dry. I don't remember.

Q. And do you recall -- you mentioned that the pupils were nonreactive in the report. Do you recall whether they were constricted, pinpoint, or dilated?

A. No. I don't recall.

Q. At the time you arrived, or at any time you were present, did you learn some of the

information, and, if so, how that's reported in this box here as far as the sweat lodge that's referred to in -- in that report?

A. When we were initially dispatched, we were just told that there was two people having two full codes in progress. We weren't aware of what we were responding to until we arrived on scene.

Q. And you mentioned later in the report that you believed that CPR was started by bystanders at 1719. Do you recall anything about the bystander who gave you that information?

A. That information was given to us by dispatch.

Q. Thank you, Mr. Chambliss. That's all the questions I have at this time.

THE COURT: Thank you, Mr. Hughes.

Mr. Li.

MR. LI: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. LI:

Q. Mr. Chambliss, good afternoon.

Now, you've been a paramedic since 2001?

A. Uh-huh.

Q. I'm sorry. For the court reporter you need to say yes.

A. Yes.

Q. And that's for the Verde Valley Fire District?

A. Yes.

Q. Now, prior to this case today -- or I should say -- strike that.

Between the incident and today, has anyone from the medical examiner's -- any office contacted you?

A. No.

Q. Anyone from the Coconino Medical Examiner's Office?

A. No.

Q. Anyone from the Yavapai County Medical Examiner's Office?

A. No.

Q. How about Dr. Robert Lyon? Has he contacted you?

A. No.

Q. How about Dr. Mark Fischione. Has he contacted you?

A. No.

Q. Has any investigator from any of those medical examiner -- medical examiner offices -- have they contacted you?

A. No.

Q. Has anybody from the Yavapai County Sheriff's Department contacted you?

A. No.

Q. Now, I understand that you were interviewed by a prosecutor in the County Attorney's Office in about January 2011.

A. Yes.

Q. About two months ago, give or take? January 17th, 2011?

A. Somewhere around there. Yes.

Q. Okay.

A. If that's what you have written down, then yes.

Q. A woman named Dana Owens, a prosecutor?

A. I believe so.

Q. And she called you on the phone; right?

A. Yes.

Q. Now, prior to January 17th, 2011, had any member of the Yavapai County Attorney's Office contacted you?

A. No.

Q. And that interview was tape-recorded and telephonic; correct?

A. Yes.

Q. So the first time you had been asked by any representative of the State of Arizona about the accident on October 8th, 2009, was January 17th, 2011, almost a year and a half later, give or take?
A. **Correct.**
Q. Now, you are a paramedic?
A. **Yes.**
Q. And your job is to stabilize patients for transport to the hospital?
A. **Correct.**
Q. And monitor their conditions?
A. **Yes.**
Q. And if there's some life-saving technique that you can deploy on a person who's potentially dead or very close to death, you are also authorized to do that; correct?
A. **Within my protocols. Yes.**
Q. Within your protocols. But you are not a doctor?
A. **No.**
Q. And your job is not to diagnose conditions or anything like that, is it?
A. **Correct.**
Q. You do provide information to treating

physicians; correct?
A. **Yes.**
Q. But you don't make a diagnosis about the patient -- a medical diagnosis about the patient?
A. **No.**
Q. In fact, your protocol is explicitly not to make that diagnosis; correct?
A. **Right.**
Q. If we could just focus for a second on the -- on the facts of -- of what happened at this accident. You arrived on the scene at about 1740?
A. **I believe so. Yes.**
Q. I'm going to --
Your Honor, if I could approach?
THE COURT: Yes.
Q. BY MR. LI: This is Exhibit 374. If you can have this in front of you if it helps you remember the times and that sort of thing. It's not a memory test.
Now, you arrived on scene at about 5:40 or -- or 1740?
A. **Yes.**
Q. And the ambulance was dispatched at 1721; correct?
A. **Yes.**

Q. So it took about 19 minutes, give or take, to arrive on scene?
A. **Yes.**
Q. When you first arrived, you and your partner went immediately to two people who were down behind the structure?
A. **We had to grab some of our equipment and then proceeded to the patients. Yes.**
Q. So you went in back of the truck, grabbed your equipment, went straight to the patients; correct?
A. **Yes, sir.**
Q. And you didn't need -- you just knew where to go; right?
A. **Well, we were directed by somebody that was there. And they directed our captain, and he told us which way to go and where the patients were.**
Q. Okay. And there were two patients who were down?
A. **Right.**
Q. A man -- oh. Actually, you don't recall whether it was a man --
A. **Wasn't sure.**
Q. There was definitely a woman there;

correct?
A. **Yes.**
Q. And you ended up working on the woman?
A. **Yes, sir.**
Q. And later you ended up learning her name was Kirby Brown?
A. **Yes.**
Q. Now, when you approached the two people who were down, there were people performing effective CPR on them; correct?
A. **It appeared that way. Yes.**
Q. And there were two-man teams, two-people teams, on each patient?
A. **Yes.**
Q. One doing compressions and one -- you know -- working on -- giving breathing, artificial breathing?
A. **Respirations. Yes.**
Q. Respirations. Now, did one of the people -- did any of the people who were performing the CPR -- did anyone identify herself as a doctor?
A. **I don't recall.**
Q. Do you remember a woman -- a doctor named Jeanne Armstrong? She's probably about this tall, sturdy.

A. I don't recall. I wasn't really focusing on who all was standing there. I was more focused on what I had to do with my patient.

Q. Fair enough. And did another person identify herself as a registered nurse?

A. I -- I don't recall.

Q. Okay. But the CPR you were seeing was, as far as you could tell, being done effectively?

A. Yes.

Q. And you started to talk to the people who were performing CPR?

A. Yes.

Q. And you gathered information from them?

A. Yes.

Q. How long have you been doing this?

A. Right. How long have you been doing CPR? Has there been any changes? And there were -- there were none.

Q. Okay. And they reported to you that, in fact, there had been -- they'd been doing it for a while but that there had been no change at all?

A. Yes.

Q. And your partner went to the other patient; correct?

A. Yes.

Q. And what's your partner's name?

A. Greg Vanderhaar.

Q. Okay. And from that point forward, when you -- you know -- sort of focused in on -- on Ms. Brown, you were almost like, tunnel vision on her, and that's what you were working on?

A. Yes.

Q. If we could talk a little bit about her -- her condition. Now, you arrived on scene at 1740, and you started work on her within a minute or two; correct? About 1742?

A. Yes.

Q. And when you -- before you started working on her, you made a quick evaluation of her vitals and just of your observation of what your patient was up to at that particular moment; correct?

A. Yes.

Q. And she was unresponsive?

A. Yes.

Q. She did not have a pulse?

A. No.

Q. She had no blood pressure?

A. No.

Q. She was asystole?

A. Yes.

Q. And that means no heartbeat; correct?

A. Correct.

Q. If we could just focus on the line where it says, pulseless. There you go.

So she was in full cardiac arrest?

A. Yes.

Q. Which means the heart has stopped?

A. Correct.

Q. There is no pulse?

A. Yes.

Q. And "apneic" means no breathing; correct?

A. Right.

Q. Now, you indicated and -- that her skin was warm?

A. Yes.

Q. But you didn't indicate that it was hot?

A. Right.

Q. And, in fact, you didn't really know what her temperature was?

A. We did not.

Q. And that's because you were focused on the lack of the pulse, the lack of breathing, and no blood pressure and all of those issues?

A. Correct.

Q. She was cyanotic around the lips?

A. Correct.

Q. Which indicated to you, I believe on direct examination, that she was not -- she had no oxygen?

A. She didn't have adequate oxygenation.

Q. Yeah. I'm sorry. Let me rephrase that.

She didn't have adequate oxygenation?

A. Yes.

Q. And you were not aware, I believe you said on direct examination, of any efforts to cool her down; correct?

A. Correct.

Q. Any effort -- you were not aware of any efforts to put water on her or anything like that; correct?

A. I don't recall if they had done that or not.

Q. Okay. And you started at 1742 CCR; correct?

A. Correct.

Q. And "CCR" stands for what?

A. Continuous compression resuscitation.

Q. And, essentially, it's an updated form of CPR?

A. **Yes.**
Q. And it was actually developed down in Tucson. And it has much better effect, or at least many people think it has much higher ability to save lives than regular CPR; correct?
A. **That's what the studies are showing.**
Q. And CCR requires fast compressions, about a hundred a minute?
A. **Yes.**
Q. And unlike CPR, you don't spend as much time dealing with -- you know -- breathing into the person's mouth; correct?
A. **Correct.**
Q. Now -- and I don't recall if I said this, but the compressions are about a hundred a minute?
A. **Yes.**
Q. And at about 1743 you attached her to a LIFEPAK 12, which is made by a company called "Physio-Control"; correct?
A. **Correct.**
Q. And that's a device that both monitors the heart; correct?
A. **Yes.**
Q. And it also, if necessary, is able to deliver a shock?

A. **Yes.**
Q. A defibrillation can -- you know -- do a shock in support of defibrillation; correct?
A. **Yes.**
Q. Now, you attached four leads to Ms. Brown's torso; correct?
A. **Arm and legs.**
Q. Arm and legs. And the -- the reason to do that was to confirm whether she really was asystolic?
A. **Correct.**
Q. And, in fact, she was?
A. **Yes.**
Q. So there was no heart rhythm, no electrical activity?
A. **No electrical activity in the heart.**
Q. And under those circumstances you did not -- although you had attached the paddles, the equivalent of the paddles to her torso, you did not deliver a shock, did you?
A. **No. I did not deliver a shock.**
Q. And the reason is because -- because she's, essentially, flat line? Or at least there's no electrical activity, there's no shockable rhythm; correct?

A. **She was asystolic. So there's no shockable rhythm.**
Q. So it would make no difference whatsoever -- you know -- based on what you saw whether -- if you shocked her or not? It would make no difference?
A. **I can't answer that. I'm not -- as a paramedic through my medical direction, we're not allowed to shock asystole.**
Q. Okay. So when somebody is asystolic, you don't shock them?
A. **Correct.**
Q. At 1744 a nonrebreather mask was placed on Ms. Brown?
A. **Correct.**
Q. And she was not breathing on her own; correct?
A. **Correct.**
Q. And at 1745 you inserted two I.V.s into her arms; correct?
A. **Correct.**
Q. One on each, left and right?
A. **Yes.**
Q. And you used an 18-gauge catheter?
A. **Yes.**

Q. And 18 gauge is, basically, the standard that you use out in the field?
A. **We have a variety of sizes that we're allowed to use.**
Q. And that's just the standard one that you use; correct?
A. **To get fluids in. Yes.**
Q. Okay. And the rate was what? 500 cc an hour, give or take?
A. **I don't think it was documented.**
Q. What's your normal protocol?
A. **It depends on -- on the patient and what's going on.**
Q. Okay. Your -- your goal --
A. **Every patient is different.**
Q. Understood. Your goal with an asystolic patient who is not breathing, who has no blood pressure, who isn't -- who you're not going to shock, is simply to -- to provide fluids to go -- or to provide volume, blood volume, to go through the body and deliver oxygen if possible; correct?
A. **You're establishing an intervenous line, which is also a medication route --**
Q. Okay.
A. **-- into the body. It's not necessarily**

for fluid resuscitation. For that particular patient it's for a medicine route.

Q. Okay. And that's exactly where I was going.

So what -- the reason to put an I.V. into somebody who has no blood pressure is so that when you inject epinephrine into the body, it actually circulates into the body, to the heart and hopefully will have the effect that -- the desired effect; correct?

A. With effective compressions.

Q. Okay. And so the purpose, again, is to make sure that the medicine doesn't just stay in the arm but that it actually circulates into the rest of the body hopefully?

A. That's the goal with the compressions. If you don't have the compressions or a heartbeat, the blood doesn't circulate.

Q. And if you shot it into the arm, it would just sit there?

A. It would just sit there.

Q. Okay. And so, in fact, that's what you did. You -- you know -- you attached an AutoPulse to the -- to her torso; correct?

A. Yes.

Q. And the AutoPulse is, essentially, an automatic compression device?

A. Yes.

Q. And it delivers a hundred beats -- or a hundred compressions per minute?

A. Yes.

Q. And then you injected one milligram of EPI, epinephrine, into the I.V.; correct?

A. Yes.

Q. And, again, the reason is hopefully that will kick start the heart?

A. Yes.

Q. But it didn't?

A. No.

Q. Now, at some point -- and I will not be able to pronounce this -- but you also attached an OPA; correct?

A. Yes.

Q. What's that pronunciation for that?

A. Oropharyngeal airway.

Q. Okay. And the reason behind that is to keep the airway clear?

A. To keep the tongue off the back of the throat so that you have an air passage.

Q. So that when you're putting the oxygen

on, it actually is getting effectively delivered to the body; correct?

A. Yes.

Q. Now, you continued to deliver these CCR protocols for approximately 16 minutes?

A. Yes.

Q. And then during that entire time Ms. Brown was -- continued to be asystolic; correct?

A. Yes.

Q. Then at approximately 1756 she was loaded onto the ambulance; correct? And that's probably up on the leave-for-hospital line that you --

A. Right there.

Q. So at 1756 you loaded Ms. Brown onto the -- into the ambulance; correct?

A. We were already in the ambulance. That's what time the driver was behind the wheel and left the scene.

Q. Okay. Thank you.

A. So we had -- we had established her in the back of the ambulance as soon as we had her stable --

Q. Thank you.

A. -- stabilized. And then that's when we

left.

Q. Got it. Got it. Got it. Okay. So then at 1756 you left for the hospital; correct?

A. Correct.

Q. And she continued to be asystolic in the ambulance, as well; correct?

A. Yes.

Q. She was unresponsive to any pain stimulus?

A. Correct.

Q. Her pupils were nonreactive?

A. Correct.

Q. She was a 3 on the Glasgow Coma Scale?

A. Correct.

Q. Which is, essentially, the same as if somebody was dead; correct?

A. Correct.

Q. The ambulance drove to the hospital?

A. Yes.

Q. And this is the Verde Valley Medical Center in Cottonwood?

A. Yes.

Q. And on the way there, you delivered another shot of epinephrine; correct?

A. Correct.

Q. And, again, the hope is that somehow this might start the heart rhythm again?
A. **Correct.**
Q. And it didn't?
A. **Correct.**
Q. Now, on the way there about 100 cc's of blood came out of her mouth; correct?
A. **Correct.**
Q. And you don't know the source of that, do you?
A. **No.**
Q. But it did not come from any visible external trauma, did it?
A. **No.**
Q. And I believe I covered this earlier. But you never knew what her temperature was, did you?
A. **No.**
Q. You arrived at the hospital at approximately 1810; correct?
A. **Correct.**
Q. And during that entire time that you were working on her, which is, essentially, from about 1742 to 1810, her condition never changed?
A. **Never changed.**

Q. She -- her heart at -- the entire time that you were working on her was not breathing on -- beating on its own?
A. **Correct.**
Q. She was not breathing on her own either?
A. **Correct.**
Q. And you then turned her over -- once you arrived at the hospital, you turned her over to the doctors; correct?
A. **To the ER staff. Yes.**
Q. To the ER staff. And are you aware that she was pronounced dead at 1821?
A. **I'm not aware what time. I wasn't in the room.**
Q. Okay.
I have nothing further.
THE COURT: Thank you, Mr. Li.
Redirect, Mr. Hughes?
MR. HUGHES: Thank you.

REDIRECT EXAMINATION

BY MR. HUGHES:

Q. Mr. Chambliss, I'll be very brief. Mr. Li asked if you had ever been contacted by the sheriff's department or the medical examiner. Have you ever been contacted by the medical examiner

about any of the patients that you -- that have died?
A. **No.**
Q. In fact, you mentioned on direct that you provide a copy of your report to the hospital; is that correct?
A. **Yes.**
Q. Do you know whether the hospital, then, provides all those records to the medical examiner?
A. **I can't answer that question.**
MR. LI: Foundation.
THE COURT: He can answer. The answer stands.
Overruled.
MR. HUGHES: Thank you.
Q. And is it -- do you know whether the information in your report is -- for want of a better word, whether it's the same information you've testified to today?
A. **I guess I don't understand the question.**
Q. Okay. Do you -- do you document all the pertinent facts as you know them about what you see about a patient and how you care for the patient in your report?
A. **Yes.**
Q. Thank you.

I don't have any other questions.
THE COURT: Thank you, Counsel.
Ladies and gentlemen, do any of you have a question for this witness?
I guess not.
Then I'll ask the attorneys, may this witness be excused at this time?
Mr. Hughes?
MR. HUGHES: Yes, Your Honor.
MR. LI: Yes, Your Honor.
THE COURT: Okay.
Mr. Chambliss, you will be excused as a witness at this time. The rule of exclusion of witnesses is invoked in this case. That means that you cannot communicate with any other witness about the case or your testimony until the trial is completely over. You can talk to the lawyers, though, however, as long as other witnesses are not present.
Do you understand?
THE WITNESS: Yes, sir.
THE COURT: Okay. You are excused at this time. Thank you.
MR. KELLY: Judge, may we approach?
THE COURT: Yes.

(Sidebar conference.)

MR. KELLY: Judge, I understand the next witness is suggested as Michael Hamilton. If that's the case, I believe that we'd like to discuss with you some disclosure and order violations out of the presence of the jury. I was looking at the time. I think it's going to take a little while.

THE COURT: What's the general area for Mr. Hamilton?

MS. POLK: Mr. Hamilton is going to give background about Angel Valley, the relationship between Angel Valley and James Ray. He'll talk about the materials used to build the sweat lodge, to keep heat the rocks, the material burned; talk about the other sweat lodges.

THE COURT: Okay. I get the general idea. Okay. Why don't we take a recess and talk about this for a few minutes before we break.

Thank you.

(End of sidebar conference.)

THE COURT: Ladies and gentlemen, we will go ahead and take the afternoon recess at this time. Please be back in the jury room at 15 after. So about 25 minutes. And we'll start as soon as we

can after that. Please remember the admonition.

I'm going to ask that the parties remain here in the courtroom. Thank you.

(Proceedings continued outside presence of jury.)

THE COURT: Thank you. The jury has exited. Mr. Ray and the attorneys are present.

Mr. Kelly, you mentioned briefly at sidebar you had a legal matter you wanted to raise before Mr. Hamilton testifies.

MR. KELLY: Judge, today we move to preclude the testimony of Mr. Hamilton. And I believe, Judge, the relevant documents that I would suggest the Court needs to have in front of it is a motion to extend time for disclosure filed by the state of Arizona on March 24.

THE COURT: I've seen that. I don't have it here on the bench, but I've got a copy handy in chambers.

MR. KELLY: Related to that, Judge, is also the 49th supplemental disclosure filed by the state. And we were provided a copy today. I'm not sure whether you have a copy of that or not, Judge. I'll be making reference to it.

THE COURT: I don't believe I do. But here's

what I want to do: I want to -- I want to go look at that. I want to look at that disclosure pleading before we go into that so I can catch up.

MR. KELLY: And finally, Judge, I believe your February 28th, 2011, order admonishing witnesses -- a copy of that order is -- is pertinent to my request as well.

And those are the three primary documents that I believe is necessary to refer to in making an argument suggesting that perhaps the testimony of Michael Hamilton and Amayra Hamilton should be precluded.

And that also affects the proposed testimony of the medical examiners, which we understand are being presented tomorrow.

THE COURT: Okay. Let me look at those documents and let's get back --

Ms. Polk.

MS. POLK: I just want to clarify, Your Honor. Did I hear Mr. Kelly say that they had filed a motion to preclude Michael Hamilton or he's making an oral motion at the moment?

MR. KELLY: Judge, we're making an oral motion right now. We found out about Michael Hamilton yesterday -- last night after the testimony. We

were presided -- we were presented a list of witnesses, all of whom were healthcare professionals. And then as we were leaving the courtroom yesterday, we found out that Michael Hamilton was a proposed witness.

We asked again whether he would testify again -- today we were told three EMTs. Now suddenly Michael Hamilton becomes an issue. So it's an oral motion. Judge, we have the ability to brief this issue in writing, as well, but the state indicated he's the next witness.

THE COURT: Okay. I'm going to go read the documentation I have at this time. And I want to reassemble at five after.

Thank you.

(Recess.)

THE COURT: The record will show the presence of Mr. Ray and the attorneys. The jury is not present.

I've read the motion to extend time, which I think Mr. Kelly was referring to. It had to do with information relating to brands and types of poisons and pesticides.

Is that the one you're talking about?

MR. KELLY: Yes, Judge. It's -- my very poor

copy, not the pleading, but the conformed copy is March 24, 2011, I believe.

THE COURT: That's when I received it. I looked at the 49th and 46th supplemental disclosures.

MR. KELLY: And I assume, Judge, it has attachments?

THE COURT: No. Not the -- not the copies I have.

And then I just referred to the February 28th order. And that just had to do with witnesses not --

MR. KELLY: I lost your bailiff, Judge. But there's the -- I believe the attachments provided with our copy of the 49th supplemental are important. They're the crux of the discussion.

THE COURT: Heidi, would you make some copies, please.

Mr. Kelly, I've looked through all the information anyway.

MR. KELLY: Judge, if I may, I'll try to articulate our concerns. But, essentially, it's this: And that is back on February 28th, 2011, you entered an order admonishing witnesses that they shall not conduct research concerning this case

after receiving the notice provided by the Court.

Detective Diskin is a witness in this case, as well as Amayra and Michael Hamilton. You'll note with the attachments to the 28th -- or, excuse me -- the 49th supplemental disclosure. And I have a supplement No. 175, Detective Ross Diskin, that on March 21, 2011, he conducted a meeting with Michael and Amayra Hamilton.

Subsequent to that meeting, independent research and investigation took place by Amayra and Michael Hamilton in regards to the various aspects discussed in the police reports. They are such things as the wood used for the fire, the soil under the sweat lodge, the plastic tarp, and also the rat poisoning. And that, Judge, is in direct violation to your February 28th order.

I understand Detective Diskin is an investigator and is allowed to remain here in the courtroom and listen to the testimony. But he's not entitled to go out and conduct interviews, encourage other witnesses to conduct independent investigations or research that then is going to be used during their testimony and, as you'll notice, the testimony of the medical examiners.

What I would request at this point,

Judge, is the opportunity to place Detective Diskin on the witness stand to ask him some questions about -- you know -- why he asked Amayra and Michael Hamilton to come into his office during the pendency of the trial and whether my assumptions that I just made to the Court are, in fact, true or not. I believe it's necessary to protect the record.

There is a request of preclusion of witness testimony from Amayra -- Amayra and Michael Hamilton given this clear violation of the Court's February 28th order.

In addition, Judge, there's issues relating to the medical examiners, because you'll note that the State of Arizona in the email dated Wednesday, March 30th, provided attachments, which are detailed ingredients, in advance of their testimony, as well as photos describing rat poison that witnesses may say was used at Angel Valley at the time of the sweat lodge.

It's anticipated that the defense may question you regarding the possibility of exposure to this or other pesticides by the victims.

It is simply, Judge, improper for the government to listen to Mr. Li's opening statement,

to listen to the cross-examination of its witnesses, which culminated in the cross-examination of a doctor yesterday who said that he could not provide with certainty an opinion that the cause of death was heat stroke, and then scramble throughout the night and start providing information to rebut or contradict the defense theory in the case. We haven't had time to prepare for that. It's highly improper under 15.6, and it's in direct violation of the court order.

Before I argue any more, Judge, before you can, I would submit, make a proper determination I believe the testimony of the detective is necessary.

THE COURT: Ms. Polk, are you going address this?

MS. POLK: Yes, Your Honor. Thank you.

First of all, in the state's motion to extend time for disclosure filed pursuant to Rule 15.6(d), which the state filed on March 24th, we very clearly set forth the underlying facts to this issue that Mr. Kelly has raised. And in that motion we notified the Court that on March 22nd, in response to an inquiry from the state, that we received the emails and the 11 additional

photographs from Amayra Hamilton and in the accompanying affidavit indicated that -- that we had done so as well.

And, Your Honor, this was done at the direction of the state, the direction to Detective Diskin in response to information that we were learning during the trial to seek out and find additional information relating to the use of pesticides, and, in particular rat poisons, on the property.

There is absolutely nothing improper about doing that. And in fact, that is one of the reasons we have 15.6, is to allow the parties -- when circumstances suggest, to allow us to find additional information to help the jury find the truth and then to notify the Court and get permission from the Court to allow that information to be used in the trial.

We have followed the rules. We have made complete and immediate disclosure to both Court and counsel about the additional information that we have sought out and obtained, and then filed that motion to the Court seeking permission to use that information in the testimony of the Hamiltons.

Your Honor, to read this admonition to

suggest that witnesses -- that prospective witnesses cannot respond to the state's detective and provide information on request is simply taking this -- this court order out of context. That's not what this court order is about.

And to suggest that the state cannot conduct an adequate investigation and respond to information that is being brought forth in a trial is simply unsupported by the law.

MR. KELLY: Judge, my request without my argument was to place Detective Diskin on the -- on the stand to determine the facts.

THE COURT: I asked Tonya to go ahead and print the February 28th order because I -- I recall making that order. I know that intent was just to prevent witnesses from communicating and finding out what other witnesses had said.

Mr. Kelly, what would -- excuse me -- Detective Diskin, the information you would be seeking is just -- is what?

MR. KELLY: Twofold. First of all, the circumstances which support his calling into his office two witnesses, Amayra and Michael Hamilton, to ask them questions about Angel Valley. I don't know what the circumstances -- you have what I

have, Judge, which is a copy of -- a copy of the supplemental report.

And it indicates that I talked to Michael and Amayra Hamilton in the sheriff's office in Prescott. And then he begins to ask Michael questions about information that he learned during the presentation of the defense case in this matter. So I am -- I'm making assumptions.

The second is -- and Judge, that relates to my concern regarding a violation of the clear order of this court. And let me point out this hypothetical. If I were to direct James Ray to contact Dr. Nell Wagoner and -- before her testimony and say -- you know -- the state thinks it's heat stroke. Are you going to be able to provide any information that it's not?

I would submit, Judge, that's a clear violation of your February 28th order. And that's exactly what the State of Arizona did.

Or alternatively, even if it's not Mr. Ray, if it was a private retained investigator by the defense, it would be a violation. Simply the element of -- the state has had 17 months upon which to conduct an investigation in this case. They failed to do that in a critical aspect of

their case, which is causation.

They can't rehabilitate that during their case in chief. They can't go out and now just bombard the defense with a bunch of evidence hours before each witness and then sit here and argue to you that that's a fair trial.

And 15.6, of course, handles this, Judge. Because the second purpose -- proposed purpose of Detective Diskin's proposed testimony is that you have to make a finding that the material or information could not have been discovered or disclosed earlier even with due diligence, and that the material or information was disclosed immediately upon its discovery. So it's a twofold finding the Court has to make.

Judge, I have an outline, a chronological outline, as to each paragraph based on the state's evidence beginning October 8th of 2009, with organophosphates, proceeding through the wood, the rat poisoning, the toxicity, with the dates.

And the second purpose of putting Detective Diskin on the witness stand is to establish the record that -- in regards to discovery with due diligence that the government had 17 months upon which to find this information

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out and it was not simply after Mr. Li's opening statements or the cross-examination of various witnesses.

So the proposed testimony of Detective Diskin is twofold. One is under what circumstances did he violate the Court's order of February 28th; and, secondly, the due diligence finding requirement of this court.

Because I submit, Judge, that there's a difficult decision to be made here. And that is absolute preclusion -- that is our request -- as to Michael and Amayra Hamilton for the remaining portion of the trial for violating -- a clear violation of the February 28th order.

And the second, more difficult question has to do with now, as indicated by the emails by Ms. Durrer to the medical examiners, what is the Court going to do with the fact that, contrary to Rule 15 and the court order, the government has provided information about rat poisoning, which is an independent investigation conducted by Michael Hamilton in -- in 2011.

What do we do about that? Do we -- do we grant more time upon which the defense can interview these medical examiners to determine what

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impact that has on their opinion? The rule states that preclusion is not the remedy. But I would suggest that as it relates to the Hamiltons --

And keep in mind, Judge, they -- and you don't have all the information that I do. They took photographs.

THE COURT: I saw the reference to it.

MR. KELLY: Yeah. They -- they included ingredients from rat poisoning that they bought purportedly this year, 2011. They contacted the wood manufacturer, Hilltop Homes. They -- they received an affidavit, which was disclosed to us, from a Mr. Dan McKenna who says, I confirm Hilltop Log Homes have never treated any of our logs with any chemical or pesticide.

They provide an opinion that they never used pesticides at Angel Valley. What the state has done is listened to our case, contacted -- in violation of your order, contacted Amayra and Michael Hamilton and said, here. Go fix this.

Now, I know their argument is going to be, well, we can handle it on cross-examination. And I agree that's a possibility. In other words, the credibility of witnesses is always an issue for the jury to decide.

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But in terms of due process and fairness and providing an adequate and competent defense to Mr. Ray, what do we do with this information?

As an example, I need time right now to -- if you were going to deny the motion to preclude the Hamiltons, then, from a defense perspective, we're saying, well, what do we do?

Well, one common-sense, obvious answer is get an investigator to request opportunity to inspect the premises, to come check the pesticide companies in Sedona to see whether or not they have a contract with Angel Valley, to request their billings to see whether they paid for any service of that type, to inspect the rocks they talked about, to contact the wood manufacturers. That's what we're going to have to do.

And so for 17 months this -- and keep in mind, Judge, this is the state's evidence. As I indicated, beginning with October 8th, the first responder says they suspect organophosphates. On the 29th, Deputy Brewer from the YCSO asked a criminalist if she could test the soil that was under the victims. Diskin on October 30th obtained soil samples and never bothered to test any of them.

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On January 31, 2010, Mr. Hughes interviewed Dr. Paul, the defendant's expert. And Dr. Paul said that he believed that organophosphates is a priority on his list as to cause of death. So they cannot stand here today and say they just discovered this.

I have a similar chronological event, whether it's wood, the rat poisoning, or toxicity as causation, just given the medical reports we heard. They knew about this.

And now, during the middle of this trial, they violate your order and they violate Rule 15.6. I don't think there's question about the violation. The issue is the remedy.

And as to the Hamiltons, our request is complete preclusion. Because I do not believe that their testimony can now be provided without the taint of the improper information that they obtained during the last two weeks.

As to the medical examiners, Judge -- we're as anxious to finish this trial as the Court is. So that presents a different problem.

THE COURT: I want to address two things. First, with regard to the jury, Counsel, I'm just going to send them home. I don't want them waiting

another half hour even -- if this even could be accomplished in that length of time. So I'm going to ask Ms. Rybar just to tell them to please reassemble at 9:15 tomorrow. And my usual, just parrot remember the admonition, Counsel.

And before you leave --

Any problem with that, Ms. Polk?

MS. POLK: No, Your Honor.

THE COURT: Mr. Kelly?

MR. KELLY: No.

THE COURT: I don't want the jury waiting while we work on this legal issue. So thank you.

The other thing I want to address, Mr. Kelly. This order admonishing witnesses, that did not remove the usual admonition that a witness can talk to an attorney and work in -- in that fashion. It was -- it was not -- the main concern with this order was the fact that there was television streaming, presented all kinds of problems, potential problems; and we wanted to head those off. That was the real focus of this.

I can see what you're saying about a possible problem with the rule, though. If somebody who's seeing testimony then talks to other witnesses about that possible -- or, I'm sorry.

Talks about that testimony, I guess it could implicate the rule. But --

MR. KELLY: Judge, if I could just sum up real quickly our concerns.

First of all, I note the email communication between Amayra Hamilton to Detective Ross Diskin dated March 22nd. It says, here are the photos of the pump house that you requested. So obviously this is a directive from another witness in the case, not from an attorney. And I believe that's an important distinction, Judge. I understand he's the investigator for the State of Arizona. But that doesn't provide him blanket immunity from court orders.

More importantly, Judge, I listened to Ms. Polk's arguments in -- in regards to the motion, which was filed March 24th, to extend time under Rule 15.6. There had been no order granting it. You had not signed the order. And yet the State of Arizona still provided that information to the medical examiners. And then -- then told us yesterday afternoon that they were going to present the testimony of the witness, the very subject matter of the motion that had yet to be granted by the Court.

In regards to seeking the truth, and I think I addressed this, the fact that all they're trying to do is conduct an adequate investigation, Judge, they've had 17 months, as I outlined in the chronology of the information gleaned from the state's evidence in this case. And I simply don't understand how they can now say we need additional time to conduct an investigation when, in fact, they've had 17 months.

Finally, Judge, the issue here, and we've argued this from the very first day, that the constitutional rights lie with the individuals in the United States and not the government. And Mr. Ray is entitled to a fair trial. And part of that fair trial is notice, which is governed from the indictment all the way through Rule 15.

And the notice we received once we received that as to the state's theory of the case, we prepared our defense. Now to allow this type of conduct during the pendency of -- right during the middle of the trial affects our ability to provide Mr. Ray a fair trial.

That's the issue, Judge.

THE COURT: Ms. Polk.

MS. POLK: Thank you, Your Honor.

First of all, again, there's absolutely no legal authority for this motion or the position that Mr. Kelly is taking. The reason that the state is entitled -- or the parties are entitled to a case agent is specifically for this purpose, so that the state can respond to information in a timely fashion.

We did send out Detective Diskin to follow up on information relating to organophosphates to -- new information that was being elicited from the defense during the trial. And we made no secret about that. We timely disclosed to the defense the report that Detective Diskin prepared indicating that on March 21st he did talk to the Hamiltons, asked them specifically for this information, and that they then took photographs and returned information to him.

So it's no secret. We completely disclosed what the state was doing from the moment we did it. As quickly as we could disclose it, we did, very timely disclosed Detective Diskin's conversation with the Hamiltons.

I agree with the Court to somehow read the fact that the Hamiltons had been listed as a --

as a witness -- to somehow read that court admonition to suggest that we cannot contact them for further information is not supported. That's not what that order was about. And the Hamiltons have not violated that order by responding to a request from the state's detective.

Your Honor, we know that the defense is doing the same thing, and it is permitted. There was a request and a disclosure to the defense today. They made a public records request to the Yavapai County Planning and Zoning Department for records relating to the Angel Valley property. And that was disclosed to them and at the same time provided to us.

So to suggest somehow that they can engage in ongoing discovery when the state cannot is not true. And again, Rule 15.6 allows that and allows each the issue to go before the Court.

I think it's important, Your Honor, to review this whole issue of organophosphates, because I think what -- the history is being twisted a bit to, frankly, mislead the Court.

First of all, the state's -- or the defense's expert, Dr. Ian Paul, was retained by the defense very early on. And a report was not given

to the state until -- I believe it was January of this year. The state had made repeated requests to interview Dr. Paul, and the defense repeatedly told us that he was not ready to be interviewed, nor was his report ready.

When we finally were able to interview him, the time to file a -- the motion deadline imposed by the Court had already expired. And it was only after the expiration of that motion deadline in this year that the defense made Dr. Paul available to the state for an interview.

We then interviewed Dr. Paul. There is no -- and we were provided with his report. There is no mention in Dr. Paul's report about organophosphates. It is not in the written information provided to the state. And it was only when Mr. Hughes conducted the interview of Dr. Paul that Dr. Paul -- and this is in January of 2011 -- mentioned something about organophosphates to the state. But there had been no disclosure of that prior to that time.

And then Dr. Paul, in the interview with Mr. Hughes, admitted that he had suspected or that this organophosphate element was a part of his opinion and that he had had that opinion the prior

May -- I believe it was May of 2010.

So even though it was not in his report, it was never disclosed to the state. It was not until this interview in 2011 that the first -- the state first learns of this issue of organophosphates. And then there had been no other information about organophosphates ever provided to the state.

When Mr. Li did his opening statement to the jury, he played a clip and showed a transcript of a reference to an organophosphate. That information, Your Honor, was not provided by a first responder. That particular interview -- it's an interview being conducted, I believe, by a Yavapai County Sheriff's Office detective. They are interviewing somebody, and then there's background that the defense picked up. So somebody in the background is saying something about organophosphates.

And you -- I'm just looking at the overhead because the defense is flashing something on the overhead.

MR. LI: I'm finding the transcript, Your Honor.

THE COURT: I'm not -- I'm listening to you,

Ms. Polk. Sorry.

MS. POLK: Okay. And so it's background. It's somebody -- it's an unknown male who mentions something about organophosphates. The recording doesn't clarify who that person is. There's no reason to believe it was a first responder. Or perhaps it is. We simply don't know. Nobody has been able to identify who that speaker is.

And there's a reference. The defense put it up on the overhead. It says, unknown male. We're not exactly sure why. Could have been some carbon monoxide with maybe some organophosphates. Maybe they were mixed in somehow.

That statement through this trial has taken on, through the defense, this life of its own to where, when Ms. Do was cross-examining Dr. Cutshall, she was saying, did you know that they suspected organophosphates? That's not what this clip says.

And, again, this is not the person who was doing the interview. This is somebody in the background that the defense, when they transcribed this recording, picked up. And that transcript was not provided to the state until -- I don't know where -- frankly, I don't know that the state has

it to this day. I imagine that we do. But we're not quite sure. I would stand corrected by the defense if they have provided it to us.

But -- so this suggestion by somebody that it could be has been taking on a life of its own. It's not something that the -- was made known to the state, not to Dr. Paul or anybody else, in a timely fashion.

And then it's only through the course of this trial, Your Honor, that suddenly the defense is questioning witnesses about ant piles and -- and the absence of ants in the sweat lodge. That's the kind of information that the parties are allowed to respond to under the rules.

This is exactly the situation that Rule 15.6 is designed for, and that's exactly why the parties are allowed an investigator at trial, so that we can, then, timely respond to information, which is exactly what the state has done.

Your Honor, I don't have my correspondence log in front of me. But the state had requested from the defense copies of the transcripts that they had made. And the defense refused to give them to me unless I agreed that

they could be used at trial. And I was not willing to make that agreement not knowing if the transcripts were valid or not.

And so the defense never provided this transcript or any other to the state until the trial started. And then when the trial, started we were provided with transcripts. That's after the trial had already started. I assume this transcript was among the transcripts we were provided. But from this clip we don't even know what transcript this is coming from.

But just to summarize, Your Honor, that the -- this clever twisting to suggest somehow that the state has always known that organophosphate was an issue is exactly that. It's a clever twisting.

Organophosphates is a complete red herring. There is going to be no evidence in the end to support the idea that organophosphates was the cause of death. It's this complete red hearing.

And the defense is doing it because that's what a strong defense does. They -- they try to come up with some issue and distract the jury to get them to go down some other path. They're doing it. They're doing it well. And the

state is allowed to respond to make sure that we get the truth out there. And that's what we're doing.

It's allowed. It's completely supported by the law -- sending out a case agent once the state learns through the defense's cross-examination of witnesses that now they're saying, well, it was insecticide because there's no ants at the area of the sweat lodge.

Your Honor, I believe you have seen this develop as well through the trial. They are allowed to do that. And the state is absolutely allowed to respond and to search out information so that we can then react or present evidence so that the jury is entitled, then, to find out exactly what happened out there.

THE COURT: Mr. Kelly, when was the report first disclosed by your expert -- the report by your expert? When did the state get that?

MR. KELLY: Our expert, Dr. Paul?

THE COURT: Yes.

MR. KELLY: His report?

THE COURT: Uh-huh.

MR. KELLY: Go ahead.

MS. DO: Your Honor, I don't recall the

specific date, but I believe it was the first week of December.

And I need to correct the chronology that Ms. Polk laid out. Mr. -- or Dr. Paul was retained by the defense in about, I believe, late May. And he was provided with the autopsy reports and the medical records of the three decedents. He had not reached an opinion or conclusion. He did not write a report.

We then were waiting for additional disclosure from the state. And at about August to September we then gave our expert the entire file of the state's disclosure, which at that time was about 4,000 pages of records.

Unlike the medical examiners for the state, we wanted to make sure that Dr. Paul put his eyes on every single record and reached whatever conclusion he was going to reach without us, essentially, selecting what he should look at.

He finished his review in about late November. And we were in constant contact with Ms. Polk's office, giving her status updates of where Dr. Paul was in his review of the records. He completed the review of the records by, I believe, the beginning of December.

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I told Ms. Polk, and this is in written correspondence, that Dr. Paul was going to write his report but he had, I believe at that time, a two-week personal vacation. They got the report the minute it came into my hands. As soon as the state asked for an interview, we set that up.

Dr. Paul reached a conclusion that he did not believe the evidence was consistent with heat stroke, that he believed there was a secondary process, given the fact that there is time lapse of about at that time 14 months, the destruction of the evidence, the fact that he cannot go back and complete the investigation that should have been done at that moment. He really can't say what it is.

It was during the interview in questions presented by Mr. Hughes that the doctor then said, okay. Well, these are all the things that I would look at. And I would note for the record that Dr. Paul has not to this day ever heard this tape. And he came to his own conclusion that one of the things that he would look at as priority given the signs and symptoms are organophosphates.

And I think the -- the -- the argument that this is a red herring is -- is really

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disingenuous given the fact that their own witness yesterday testified that he cannot rule out organophosphates.

So the suggestion that we have been hiding the ball or not providing disclosure is just inaccurate. It's not true. They've gotten it as soon as we've gotten it.

And I think that Mr. Kelly's point, going back to the fact that organophosphates was not mentioned by our expert but by their own witnesses in their own evidence on the night of the 8th, they know it. Our expert doesn't know it.

THE COURT: My first question had to do with when the report was provided. And I think you said in December. And I wanted to know what that mentioned about pesticides.

MR. KELLY: If that's a specific question about Dr. Paul's report, I would defer to Ms. Do.

MS. DO: Your Honor, his report was directed to evaluating the state's evidence supporting whether or not it's consistent or inconsistent with heat stroke. His final sentence in the report, I believe, is not only is it inconsistent but he believes there is some, quote, unquote, secondary process going on.

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THE COURT: That's what the substance of the report was. Then there was an interview done by Mr. Hughes in January?

MS. DO: I believe so. I can't remember the exact date.

THE COURT: And then -- maybe I need to ask Mr. Hughes if that January interview --

Was there discussion of organophosphates as possibly being a cause?

MR. HUGHES: Your Honor, I did ask the doctor in his interview if heat stroke didn't kill these patients, what did he believe killed them? That's when he mentioned that he believed organophosphates maybe -- or organophosphates was the immediate problem.

I'm sure the defense has a transcript of that interview by now. That was the first time I had heard organophosphates. It wasn't mentioned in his report. At that point in time I asked him, well, how long have you had this suspicion? And he said it was either April or May of last year that he had -- had a suspicion or belief, or something along those lines, that organophosphates may have been the culprit in this case.

We didn't find about it until after the

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discovery deadline was done and literally during the time of that interview.

MS. DO: Your Honor, Ms. Seifter is going to get the transcript of Dr. Paul's interview.

And that is absolutely incorrect. Dr. Paul never said he had a suspicion it was organophosphates back in May or anytime sooner than -- when the report was issued, he said secondary process pursuant to additional questions by Mr. Hughes. And he elaborated.

And, again, Dr. Paul isn't saying he believes it is organophosphates. His hands are tied because of the fact time has lapsed, evidence has been destroyed.

So that's absolutely incorrect. He did not come to that conclusion in May. We'll get the transcript if the Court wants to review it.

MR. KELLY: Judge, if I may reply to Ms. Polk, unless you had some specific questions?

THE COURT: The dates could be fairly important in January. I recall I extended the deadline once and did not extend it the second time as it got so close to trial, it was just time that the positions had to be taken and -- and the trial was going to proceed.

There had been rescheduling of the trial, everyone will recall, in early July when I had to -- to get involved in another matter. And -- this case was going to go to trial at the end of August. And it didn't go at the end of August, and it got set all the way into the middle of February, essentially seven months away, five and a half additional months from the original setting. And I didn't grant the second request with regard to experts. I did grant the first, as I recall.

Mr. Kelly.

MR. KELLY: Judge, here's the real red hearing in this case is the government's own medical records marked as exhibits are replete with references to toxidrome, toxicity, toxins, these other suspicions that the -- beginning with the EMS providers, the emergency room doctors, the ICU docs. They all have that same suspicion.

Under that broad umbrella the toxin lies in organophosphate where this particular EMS provider -- he identified that as a possible cause.

And please keep in mind, Judge, that we cannot shift the burden of proof here to the defense. And -- and that's what it sounds like the state is trying to do. We don't have to prove

anything.

And so whether it is -- and the Hamiltons' violation of the court order is broader than just organophosphates. It also includes the wood. We brought that up, that perhaps if you burn treated wood, that may cause one of these toxins identified by the medical doctors.

Also, in addition to the pesticides, the rocks -- they're natured. Whether or not they were -- whether it was heated and it could be something different given the coarse nature of the rocks. The rat poisoning in the shed was identified by the fire keeper back in October of 2009.

And when I speak -- when I hear the state say they want to -- just for a search for the truth, what's almost comical is that this latest disclosure is the Hamiltons taking out some rat poisoning in 2011 and putting it in a pump house and taking a picture of it.

It's not the rat poisoning that was referred to by Ted Mercer that should have been discovered, should have been disclosed, under Brady as potentially exculpatory.

Now they want to come back some 17 months

later and say, oh, we didn't know about this, so here's a picture of some rat poisoning. And Ms. Hamilton said on -- I picked the lowest toxicity rat poisoning I could find. That is grossly unfair when you're attempting to provide a defense.

We were relying on the state's evidence. When that evidence made reference to organophosphates, to toxins, to the rat poisoning, to the rocks they used, to the wood they burned, all potential toxins, which were easily gleaned from the medical record.

So the government cannot come in here now and say we did not have knowledge of this defense asserted by Mr. Ray. That is simply impossible.

Judge, again, I think the record needs to be complete because under 15.6 you need to make a finding that the material or information could not have been discovered or disclosed earlier even with due diligence. And the problem here is there's been a complete lack of diligence on the part of the state.

I have -- and I was going to ask Mr. Ross the relevant dates. I believe I articulated them when organophosphate references were made

October 8th, October 29th, October 30th, 2009, and then again January 31, 2011, the interview of Dr. Paul.

THE COURT: What -- what do those other dates relate to? References --

MR. KELLY: The first is the first responder, the exhibit that's up on the overhead. The second, October 29th, 2009, Ken Brewer from the Yavapai County Sheriff's Office asks Criminalist Sy if she could test the soil that was under the victims because of there was suspicion regarding toxicity.

On October 30th, 2009, Detective Diskin returned to Angel Valley. He obtained additional soil samples for that purpose. And this is the corroboration of those facts. It's the actual communications log from the sheriff's office, Judge. Exhibit 584.

So, then, finally, as you inquired, there was an interview of Dr. Paul. Those are four instances in which due diligence would require the State of Arizona to inquire into this possible cause of death.

In regards to the wood, it's more extensive. It's October 8th, October 9th, and October 9th, 2009. Three separate instances when

Detective Diskin and Detective Edgerton knew of problems with the wood or suspected problems.

On October 14th the YCSO contacted the criminalist again about testing the rocks, tarps, and the wood. On February 4th, 2010, the criminalist finished her trace analysis. She found volatiles in some of the items tested. This is one day after the indictment.

And during the interview of May of 2010, the criminalist said no one ever -- from the State of Arizona ever bothered to ask her about her conclusions. And then, of course, we conducted a three-day evidentiary hearing in November when the wood was discussed in front of this court. And yet, that's part of the disclosure violation.

The rat poisoning. It's October 9th, 2009. Mr. Mercer told Detective Diskin the tarps in the sweat lodge materials were stored with chunks of rat poison.

And, finally, the toxicity as causation. The medical records of all 3 decedents and all 15 participants make reference to that as a possible cause.

So, Judge, under 15.6 I submit that the Court has to make a finding that the government

could not have discovered this information. It was their evidence and in their possession with the exception of Dr. Paul's reference. And that simply they did not exercise due diligence.

So then, Judge, as I mentioned before, the question becomes as to the remedy. And one thing that Ms. Polk mentioned is that there's nowhere under the law that would allow you to preclude the testimony of witness.

And I take issue with that, Judge. You have a clear order that witnesses were not to go out and conduct independent investigations, and the State of Arizona violated that order. And preclusion of Amayra and Michael Hamilton would be a proper remedy.

Secondarily, I suppose -- and I hate to argue the alternative because I'm not making a concession. We definitely need more time at our expense to send an investigator out to determine the credibility of the statements made by Michael and Amayra Hamilton.

Finally, Judge, when the State of Arizona files a motion to extend time, recognizing the need under Rule 15, and then without the court order goes ahead and just does what it wants to, provides

the information regarding the rat poisoning and the photographs to the medical examiners, Judge, I would say that is just a blatant violation of the court order.

In regards to the disclosure time, it is not timely. We received one day before the proposed -- yesterday, the Michael Hamilton's notice that he was going to testify. They interviewed him on March 21, which is nine days ago. So we had to wait eight days to get that.

And then, of course, the medical examiners are testifying tomorrow. It was this morning that we got the 49th disclosure indicating these problems. We didn't have advance notice.

Judge, I believe that it's impossible for this court to find that this material information could not have been discovered with due diligence.

And I also would submit that given the fact we're in the middle of a jury trial, to wait eight days to give it to us is not timely disclosure.

Thus, you can either deny leave, grant the request and the motion, is the remedy under 15.6. And then I believe the bigger issue is why is the State of Arizona allowed to violate a direct

order from this court in regards to the rule precluding witnesses from talking about this information and conducting independent investigations.

THE COURT: Again, that order admonishing witnesses was not intended to change the basic rule of exclusion of witnesses. It was just to elaborate because of the extensive media coverage.

Mr. Kelly, are -- are you indicating that you don't think a party can contact a witness, through attorneys, which I think the rule contemplates, to prepare a witness and address matters that have arisen at trial? Are you suggesting that?

MR. KELLY: Judge, obviously an attorney can conduct a -- or contact a witness such -- let's use Michael Hamilton as an example. And in the preparation of Michael Hamilton's testimony prepare the witness and say I'm going to ask you questions about where you got the rocks. That's entirely permissible.

But it's disingenuine (sic) and flies in the face of what I talked about in terms of fairness and due process to send an investigator out eight days before his testimony and say, go get

me some -- you know -- what kind of rocks did you use? Where did the wood come from? Go get me some information regarding that wood right during the trial when you had that information dating all the way back to October 9th, 2009, when Ted Mercer said, the only difference is the wood we burned.

And then -- so the issue then becomes how do we prepare an adequate defense to that if Michael Hamilton were to get up and say, I know that that wood is not treated? And that's the first we've heard of it, yesterday afternoon.

Because the defense up to this point in time is based on this statement, the toxicity in the medical reports, Ted Mercer's statement in regards to the wood, and his statement in regards to the rat poisoning.

And, again, we don't have a burden of proof. So it's not necessary for us to go out and ask these people -- disclose our defense. But as indicated by Ms. Do, the doctor yesterday said, yeah. I can't tell you with certainty it was heat stroke. That's hardly a red hearing. That is the defense as it relates to causation.

So in -- that's a lengthy response, Judge. I apologize. But I believe it's different

when -- and I hate to use this word, but it almost appears like a setup.

When Detective Diskin goes out eight days ago, brings the Hamiltons together to his office knowing that they're going to testify, having heard from opening statement, through every witness, and not only say -- you know -- where was the tarp -- where was the tarp stored? And she says, the pump house. She writes back the next day, Ross. Here are the photos you requested. So he's actually requesting evidence.

And then, as I indicated with Mr. McKenna, an affidavit which is dated March 25, 2011, that says, Hilltop Log Homes has never treated any logs.

If we'd had known that in December, before Mr. Li made his opening statement, we would have had the opportunity to investigate, to prepare our defense, and Mr. Li may not have mentioned that in his opening statement.

MR. LI: If I may just have a comment on that one point. I would have mentioned it because actually the evidence that they're providing here, I don't even know if it's accurate or not. But we would be able to have gotten investigators to prove

one way or another what's actually going on.

I think the problem here is that the state -- I cannot believe that the state is trying to walk away from this -- this mention of the organophosphates on October 8th.

That is one of the reasons why -- why Detective Diskin should be on the stand. Because there's a question of -- if the state really is taking the position that they don't know what this tape is or where it came from or how it could actually be, Detective Diskin is a case agent. Every piece of evidence has gone through him. I think we, then, need to know, okay, really? Tell us the circumstances under which these tapes were made. Describe to us everything you know about this. And then have the state argue why they've exercised due diligence by making a disclosure today in the middle of trial, six weeks into trial. What is this? Day 24 of 65? And now we're talking about oh. Well, they don't know about organophosphates?

I'm sorry, Your Honor. I feel strongly about this because I think it's disingenuous in the extreme to suggest that this tape is not authentic -- the government's tape -- to suggest

that this is not a medical responder when he says, call 9-1-1 and we'll come back.

The fact that Mr. Hughes and I sat in a room with a witness that the state was going to call several weeks ago -- I played the tape for her, and she said, yeah. I remember that. Some EMT guy came in and said something like that.

So I don't think the state can honestly say -- Mr. Hughes was sitting there with me in the room. Ms. Seifter was there too. We played the tape. I don't think the state can honestly say that they don't -- that they don't have at least some belief that this might be an EMT.

And I think Detective Diskin should be on the stand, and I think he should explain why it is an exercise of due diligence to start looking into this organophosphates issue what? On the 30th of March.

It's just like the lawsuits, Your Honor. I mean, there -- there are so many different issues here where the state takes the position that they didn't know about something when it's been in their records --

THE COURT: Mr. Li, you've made the argument prior.

MR. LI: Thank you.
THE COURT: Ms. Polk.
MS. POLK: Your Honor, if the Court is going to rule against the state, I would like to respond. But if you're not going to, then I don't need to consume more time. But there are several issues that I would like to respond to, unless the Court is --
THE COURT: No. I'd like to hear from you.
MS. POLK: Okay. First of all, Your Honor, the defense never noticed the defense that it was organophosphates that killed these people. That was never provided to the state. And in fact, I think their strategy was to keep this as a bit of a secret to spring on the state once we had started trial.
The report from Dr. Paul is dated January 10th, 2011. So we did not get the written report from Dr. Paul until January 10th of this year. The state had repeatedly requested his report and the opportunity to interview him. And he was the only witness that the defense had noticed. And we repeatedly requested the opportunity to interview him, repeatedly requested his report. It was never forthcoming until after

January 10th of 2011.
We then requested to interview him, and the defense did not make him available until after the Court's deadline for motions, at which point he was made available. Mr. Hughes interviewed him -- and Mr. Hughes is looking through the transcript for references to organophosphates. But there was no reference in Dr. Paul's report to organophosphates. So we still didn't have this information about organophosphates.
This particular transcript and excerpt from -- from a recording was played to the jury in opening statement, offered to prove the truth of the matter asserted, even though the defense has no good-faith basis for doing so. They cannot find this unknown male.
The state has no opportunity to confront this unknown male about what his basis was for saying what he said. That's classic hearsay. And this defense sprang it on the jury in their opening statement without any notice to the state and without any opportunity for the state to respond -- to engage in timely pretrial motion practice to keep it out.
So it is out there in front of the jury,

sprung upon the state after this trial has begun with no opportunity to call this witness and cross-examine and find out what the basis was for making that statement.
Mr. Kelly referred to soil samples and suggestions that things be tested to the wood. The scene was sampled. There was no reference to organophosphates with respect to sampling or testing. It's just that the scene was clearly processed. The detectives sampled everything, had it ready in case it was needed to be tested. But when the medical examiners determined that the cause of death was heat exhaustion, then there was no need to further test.
When, again, Your Honor, that information was being held, there would have been the opportunity to timely test if the state had notice from the defense that they were going to run with this organophosphate defense.
But because it was not provided to us, it was not noted as a defense, it was not -- Dr. Paul's report was not made available to us. And when it was, it doesn't reference organophosphates. They finally make him available, and he makes a reference to it, but it's after the

motion deadline. And he just makes a reference to it.
As I recall, what he says is he believes that heat stroke was relevant, but unless you can eliminate organophosphates, he's not willing to call it heat stroke. But I would stand corrected. But that's my recall of what Dr. Paul said during questioning by Mr. Hughes.
The medical records do not specifically suggest organophosphates. That only emerges after the fact when the defense, having introduced this to the jury, then starts presenting evidence, as they're entitled to do, about organophosphates and then starts questioning doctors about whether or not you can rule it out.
But this is a defense that has been sprung on the state through hearsay used in their opening statement.
So here we are. The state is entitled to timely respond and to try to seek out information as a defense emerges at trial. I'm not suggesting that the defense is not allowed to be talking about organophosphates. But the state is certainly entitled to respond when we get some glimpse of where the defense is going.

And that's all we're getting are these suggestions here and there, and all of a sudden now they're homing in on organophosphates. And it becomes relevant then, were organophosphates used at the -- at the scene, at Angel Valley. And that's when we directed Detective Diskin to go out and interview the Hamiltons.

I would note, Your Honor, that the defense chose not to interview the Hamiltons. It's been their strategy not to interview witnesses, not to conduct defense witness interviews. That is a strategy that they're entitled to take. But they chose not to interview the Hamiltons.

And if they had, if they had asked about the organophosphates, the Hamiltons would have responded. They would have had the opportunity that Mr. Kelly is talking about to question and find out about rat poisoning and -- and when did you use it and -- and information in a timely fashion. They chose not to.

And, in fact, at the 404(b) hearing, they did not question the Hamiltons about organophosphate used on their property, even though we were clearly talking about causation. We were talking about the deaths in 2009 and this pattern

that had emerged in the detective's investigation showing that it's only with Mr. Ray's sweat lodges that there is problems.

That even though other sweat lodges using that same structure had been run on the Angel Valley property, that there are no problems. It's only with Mr. Ray's sweat lodges that there are problems.

And so it's clear, then, through that pattern that you can eliminate something like organophosphates and -- and that pattern becomes relevant to the causation issue.

But to suggest somehow that the defense has been talking about organophosphates or been arguing that as a defense for a long time is simply untrue. It was not provided to the state and was only provided through the state's interview of Dr. Paul on questioning from Mr. Hughes.

And I can see if Mr. Hughes has more information for the Court. He's had a chance to look at the transcript now of his interview with Dr. Paul.

THE COURT: Okay.

Mr. Hughes?

MR. HUGHES: Thank you.

MR. KELLY: Approach, Judge, with a copy of page 94, subparagraph --

MR. HUGHES: Your Honor, I think we may have different transcripts. Mine doesn't go up to -- to that many pages.

THE COURT: Heidi --

Mr. Kelly, just make sure it's the same text if not pagination.

MR. KELLY: While he's doing that, Judge, may I reply briefly?

We have just turned the Constitution on its head. And the state describes what should be exculpatory information and an obligation to disclose under Brady as we're not giving them an opportunity to discover their own evidence. That offends me.

They should have seen this. They should have -- they should have reviewed their own medical records. They should have interviewed with their own witness yesterday and found out that he could not testify to a medical degree of certainty that it was heat stroke and disclosed that information to us.

May I approach now, Judge, with the transcript?

And then Mr. Hughes, you may have a copy.

THE COURT: Mr. Hughes.

MR. HUGHES: Thank you. And, Your Honor, Mr. Kelly -- I haven't had a chance to -- to compare word for word. But Mr. Kelly is showing a portion of a transcript, which I agree I think is partly relevant.

However, the other portions about when the doctor reached his opinions, I'm not sure those are referenced. They came much earlier in the interview.

Your Honor, I had asked a string of questions to the doctor and -- starting with, basically, at what point do you recall reaching the opinions that you described in your report? And the -- Your Honor, it may be easier if I make a photocopy and provide a copy to Your Honor and to the defense.

But there are a number of sections where, basically, he indicates that -- I asked, do you recall when you first communicated for the first time those opinions?

And he said, for the first time my preliminary opinions were communicated in May of 2010. And that's with respect to communications

to the defense.

I asked, okay. How did those preliminary opinions differ from the opinion in this January 10th report?

And the doctor replied, not substantially.

Then there is the section -- there is the section that Mr. Kelly has provided. And, again, I'll assume that his portion of the transcript is accurate. That talks about the organophosphates and how the doctor came to -- how that came up in our conversation about organophosphates.

And then later on in the interview I had asked the question, okay. Have you reached an opinion as to the cause of Liz Neuman's death?

And he said, no.

And then we went into the line of questions which actually is, I believe, the section of the transcript that Mr. Kelly has provided to you.

Ms. Polk asked some follow-up questions as far as when he had reached his opinions. And she asked, you told us early on when Mr. Hughes was first beginning the interview that you were contacted by Truc Do in May of 2010 and that you

reached a preliminary opinion then that, essentially, did not change throughout the course of your relationship with that office. Is that correct?

And he replied, what I stated was that I generally -- generated, basically, my first opinion about this case in later May. And no. It didn't substantially change. That is correct.

Again, Your Honor, we did not -- there's no mention of organophosphates in the report. I don't know if the report has been marked as an exhibit or not. But there is no mention of the organophosphates.

It wasn't until we began to ask questions about the cause of death of these people that he indicated that if he had been the medical examiner, he believed that there -- and that part I believe is set forth, again without reading word for word, in the transcript that Mr. Kelly provided.

And it ends with, if you look at the presenting signs and symptoms of all these pesticides, it's exactly what you see in this case to the "T." And that information we learned for the very first time during this interview in January.

Now, the interviews of the experts -- there were scheduling issues. And we never filed a discovery motion. And we're not making a discovery -- at least I'm not making a discovery allegation that there was something improper. With the holidays coming up, we didn't get these interviews scheduled until January, although we had been asking for them for sometime.

Earlier in this transcript Dr. Paul does indicate that the first time Ms. Do asked him for a report, I believe it was October or November. And obviously that's when the report was first generated in the case.

But the report itself we obviously needed to receive before we could do the interview. And then with the holidays, I know things got pushed back into January.

THE COURT: Ms. Do, you wanted to address --

MS. DO: Yes.

THE COURT: -- this specific point?

MS. DO: I do, Your Honor.

Without the Court having the opportunity to listen to the entirety of that interview, what Mr. Hughes has represented has been taken out of some -- some context here.

When Dr. Paul stated that he had reached his preliminary opinions in May, that was with respect -- and I do have, I believe, documentation in which I sent information to Dr. Paul to review. I was specifically asking him, please look at this and let us know if you have an opinion as to whether or not this is consistent or inconsistent with heat stroke.

And, for the record, in May I had not yet discovered the excerpt that is now in question regarding first-responder statement about organophosphates. So when Mr. Hughes represented to the Court that Dr. Paul reached preliminary opinions in May, it's misleading to suggest that those opinions related to organophosphates. It was strictly to the state's evidence of heat stroke. So I think without the opportunity to review the entire interview, that's taken out of context.

I do want to say very briefly, Your Honor, that I think what is the red herring in this case is that we started this discussion about the state's late disclosure, and now it's being deflected and we're -- we're dealing with accusations of late disclosure by the defense.

Obviously Ms. Polk and Mr. Hughes had

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Dr. Paul's report in January. We've started trial. We're now 24 days into trial. They've never complained about late disclosure. And now they're complaining about it to deflect the very issues that are before the Court.

I would note not only are there problems under 15.6 without the ability to establish due diligence, we received this information literally on the eve before these witnesses are going to be called.

The state interviewed Michael Hamilton on March 21st. They held on to that interview for nine days, gave us the report yesterday, and told us he was going to testify today. There's no excuse for that.

They told us they were going to call the medical examiners tomorrow. They sprung it on us this morning with the 49 disclosures that on March 24, some six days ago, that they provided additional information to the medical examiners to elicit additional opinion conclusions, which we still don't even have disclosure of.

So I think what is the red herring in this case is that the state is now deflecting its disclosure violations by talking about Dr. Paul.

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That's not the issue here. The issue is giving us discovery on the eve before a witness is going to testify.

At this point we have no idea how to cross-examine Michael Hamilton because we've not had the opportunity to investigate the additional information that has been elicited. They've given us a hearsay affidavit. We don't know who this witness is. We can't cross-examine the medical examiners tomorrow because we've been told now that they've been provided additional information.

THE COURT: Ms. Do, I thought you haven't ever interviewed Michael Hamilton. Is that true?

MS. DO: No, Your Honor.

THE COURT: Is that -- is that true?

MS. DO: Yes. That's true.

THE COURT: Okay. Then I'm wondering, just on the point you make, if this information had been provided a month or two months before you wouldn't have known either. So --

MS. DO: Actually, Your Honor, I think that if -- if this information was timely investigated by Detective Diskin, all the information regarding the sand, where it was purchased, the type of pesticides used, the rat poison that was used, the

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log that was used, we probably would have interviewed. But it's difficult to say in hindsight.

The point being is I think we have that opportunity. And it would be unduly prejudicial for us to have to cross-examine on information that literally got sprung on us last evening.

So -- you know -- in addition to availing ourselves the opportunity under Arizona rules to interview the witnesses, we also need time to investigate.

They've given us the names of approximately two or three additional leads that we might want to investigate. And I think for me the concern with the medical examiners is it's far more grave.

They have a requirement under 15.1, Subsection (e)(3), to provide us with the statements, conclusions, and opinions of the experts in a timely fashion, including rebuttal under -- I believe it's Subsection (h) of 15.1. And we don't know those additional opinions or conclusions.

I emailed them this morning immediately upon receiving the 49 disclosure. I still haven't

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gotten an answer as to what additional disclosure is coming our way.

So I just think that rather than talking about a now newly complained of disclosure issue with Dr. Paul, which has never been raised before, we should be talking about the issues that Mr. Kelly raised.

MS. POLK: Your Honor, may I respond briefly?

THE COURT: Yes, you may.

MS. POLK: First of all, when the state obtained the photographs and the other information regarding -- relating to the rat poison, our practice has been to email what we have to the defense right away, and then we followed up with the formal disclosure. And my paralegal is looking for the date that we emailed the information.

But it's not true that it was provided on the eve of Mr. Hamilton testifying. It was provided probably, I'm guessing, on the 22nd or the 23rd. Our practice has been to email it out to them and then we follow up with the formal disclosure, which has those later dates on it.

I have a copy of the defenses noticed by the defendant. And they simply are a general denial, insufficient evidence, lack of mens rea,

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and lack of causation.

The reason that we are discussing the issue of the disclosure of Dr. Paul's report and our opportunity to interview him is not because we are accusing the defense of late disclosure. We are not. But we are letting the Court know when it was that the defense gave this information to us. And it's relevant to the motion under 15.6.

To suggest that the state somehow has known that the defense was that organophosphates was the cause of death for 17 months is not true. It's not true. It was not disclosed to the state. And when it was disclosed, it was disclosed vaguely through an interview by Dr. Hughes (sic) of the expert.

It has been in the course of this trial as we listen to cross-examination of witnesses that it becomes a bit more clear to us where the defense is going.

And, again, that's the whole point in having a case agent with the state or with the defense, is to allow the parties to respond to information, to find what we can, and then disclose documents that we intend to use at trial. And that's exactly what has happened here.

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THE COURT: When was the 15.2 notice -- 15.2(b) notice filed, Mr. Kelly? You mentioned causation as a defense.

MR. KELLY: Months ago.

MR. LI: I'm going to guess is that maybe May or -- I mean, certainly within the time frame required by the -- by the rules.

THE COURT: I want to go right back to the basics on this.

MR. LI: Well, it was -- it was filed timely. I mean, I don't recall what the deadlines are, but we -- we adhered to them.

MR. KELLY: Judge, I have to say -- you know -- we're still in the state's case here. This is cross-examination that we're talking about. And I take issue -- it's not a disclosure issue under 15.6. It's a due-diligence issue. Because everything we've discussed is the state's evidence.

THE COURT: I'm hearing that. There's a -- once again, there's a difference between late-disclosed materials and trying to use materials. That's one thing. It's another thing just to have the witnesses who are appropriately prepared and can discuss what they know.

MR. KELLY: And one thing I have to respond to

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is your direct question to Ms. Do about Michael Hamilton, Judge. We do have his information prior to the March 2011. He didn't say anything at the sweat lodge. He didn't observe anyone. He kept talking to Detective Diskin, and essentially saying, look, I wasn't there.

So we considered him to be a marginal witness. We knew and we believed that there was relevant information due to the fact that he was the owner and operator of Angel Valley and that he had sued James Ray International and he had been sued.

But that was the sum total. And I was responsible for his cross-examination, when lo and behold, now we have this other information we've discussed today. And we haven't had a time -- a chance to ferret out the information.

What -- you know -- just simply on relevance basis, what would a photograph taken a year and a half later have to do with the event? Picture of some rat poisoning.

Judge, I -- to answer your question, the disclosure, our disclosure, was months and months ago.

MR. LI: We're getting it, Your Honor. Miriam

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tells me that she thinks it was in March. And we're just going to get it and give it to the Court.

THE COURT: If there has been any violation of the -- the rule or order, it is going to be basic rule of exclusion. And I -- I don't know that I've heard anything that -- that would qualify just from what I've heard. That's how it's going to be analyzed, as I've stated before.

I'm not saying that there is or is not a violation here. But it would be just based on -- on the rule of exclusion, not on my order, which was designed to prevent witnesses from seeing other witnesses' testimony on media, looking into sources that would give them access to testimony.

Who were you planning to call tomorrow, Ms. Polk?

MR. HUGHES: Your Honor, the state intended to call Dr. Lyon tomorrow -- who is one of the medical examiners.

THE COURT: I remember his report. His report pertains directly to whom?

MR. HUGHES: It pertains to Kirby Brown and James Shore.

THE COURT: Let's talk just about that

anticipated testimony. With regard to that, Mr. Kelly, that testimony, what are you maintaining would be subject to some type of sanction under 15.7?

MR. KELLY: Well, first of all, Judge, on March 28th, 2011, a copy of the letter -- and you have a copy of it so -- addressed to Dr. Lyon and signed by Kathy Durrer, the paralegal for Ms. Polk. Paragraph 5, medical records of Daniel Pfankuch, a 2005 sweat lodge participant, was provided to the doctor. We believe that's improper if he's going to somehow base an opinion. It's simply attempting to backdoor the 404(b) preclusion.

Other than that, Judge, Dr. Lyon is Ms. Do's witness. And I believe she can better answer your specific question.

MS. DO: Thank you, Your Honor.

The disclosure -- the 49th disclosure, which we received this morning, includes letters in which the state has sent additional information for the medical examiner's consideration as to cause of death. I would note that the earliest letter is dated March 24th, 2011, and an additional letter with additional material disclosed March 28th, yet we're getting it this morning.

Mr. Li and I interviewed Dr. Lyon and Dr. Mosley beginning in May and June of 2010. We reinterviewed again in January of 2011. As of January 2011, both of these medical examiners had not reviewed any materials beyond the specific decedent's medical records.

Now the state has provided these medical examiners with the medical records of the entire group of participants who went to the hospital. And that would be the equivalent, I believe, of 18 separate set of medical records, in addition to the information recently obtained by Michael Hamilton about the rat poison, the pesticides, et cetera.

I assume the state did this in order to elicit additional opinions from the medical examiners.

While we received disclosure of what was provided, we did not receive disclosure of what their opinions are now upon receiving this additional set of information.

So I'm prepared to cross-examine Dr. Lyon based upon the status quo as of January 2011. At this point I don't know what else he's going to offer. And I would like the opportunity to, one, get that disclosure from the state and determine

whether or not I need to do an additional interview or determine, three, whether I need to prepare for additional information on cross-examination.

I think it's just completely unfair to have sprung this on us this morning when they told me yesterday they were going to call Dr. Mosley and Dr. Lyon for tomorrow. There's no excuse for why they held on to this information for even one extra day.

But it's clear from the information that they gave us they provided this information with the intention of getting additional opinions from these medical examiners as early or as late as March 24. So I just don't know why we're talking about this six days later.

So unless the Court is inclined to grant us more time to deal with these issues, I think what's proper under 15.6 is preclusion of any additional new opinions that these medical examiners have now come up with after I did the second interview in January of 2011.

THE COURT: Mr. Hughes or --

MR. LI: Your Honor, if may I approach with the notice of defense. It's a bad copy. Our printer is not working very well.

THE COURT: Mr. Hughes.

MR. HUGHES: Thank you, Your Honor.

Your Honor, it's appropriate and permissible under the rules of evidence for an expert to testify and reach conclusions based on evidence that's not otherwise in evidence. There are rules that specifically govern an expert doing that.

It's appropriate for the medical examiner to testify and give an opinion in court tomorrow, first of all, about the cause of death as set forth in the autopsy report. And it's certainly appropriate for him to explain whether that opinion has changed at all in light of additional information that the state provided recently to the medical experts.

With respect to the photograph of the possible rat poison that was used, it's appropriate for the state to ask the expert if he's aware of what the signs and symptoms would be or what a patient -- deceased patient would look like if they came into his office for an autopsy and they had ingested rat poisoning.

And it's my opinion -- although I haven't talked to the doctor since we provided this

information, it's my opinion that the doctor is going to stick by his original conclusion as to the cause of death.

Throughout the course of today, certainly, and the defense has asked witnesses -- and I believe on other occasions have asked, do you know if this was provided to the medical examiners? Do you know if this information was provided to the medical examiners?

It was that line of questions that led the state to believe that the defense intends to inquire, what did the medical examiners have from the state and from YCSO and the County Attorney's Office in determining the cause of death both at the time.

And if they didn't have that at the time they reached the determination of cause of death, now that they have it now, does that make any difference? Does that change their opinion in any way?

Again, it's my belief they're going to say that it won't change their opinion. Although I haven't had communications with them to know one way or the other what they're going to say about that.

But I do believe it's appropriate, particularly in light of the line that the defense has taken of asking, has this information been provided -- you know -- to the medical examiners, to the state, to the YCSO.

It's appropriate for me to preemptively give that information to the medical examiners and then find out from them, would that have made any difference in your conclusions that you've reached in this case.

THE COURT: Ms. Do, how does 15.1(e) relate -- relate to this? You're talking disclosure rules and --

MS. DO: I'm sorry, Your Honor. Let me make sure I cited the correct --

THE COURT: You did. 15.1(e) is what you want, additional information from an expert that the state has listed.

MS. DO: I was looking at Subsection 3, Your Honor, that deals with any completed written reports or statements. And as the Court knows, 15.4 defines statement to be -- to include oral -- oral statements.

What Mr. Hughes has just said right now indicates to me that the medical examiners are

going to offer opinion and testimony -- expert opinion and testimony regarding what their beliefs are with -- with respect to organophosphates or other pesticides as a cause of death.

We've not received any opportunity to interview the medical examiners regarding that.

THE COURT: I need to keep up as we go. We've gone through a lot of things. We've plowed some old ground here, and I don't need to hear that again, those various things.

I want to know about statements right now. Ms. Do, please sit down. Please sit down.

Mr. Hughes, I want to know about statements. Do you have a statement in any form from the -- from Dr. Lyon? Is it Lyon?

MR. HUGHES: I believe it's Lyon.

THE COURT: Do you have any statement in any form from him that would include this information that Ms. Do is concerned about?

MR. HUGHES: I don't, Your Honor. Again, statements as defined under 15.4. This information has been recently provided. We've not -- and you can see our transmittal letters. We've not asked the doctors even to look at it if they don't want to. We're just providing it to them.

But I do not have a statement, a writing. I don't have a conversation with them that I took notes. I don't even have a conversation with them --

THE COURT: That was my next question. And I only want to interrupt because I want to get right down to what I think the issues are. I don't want to go back through the general statements of positions on the case.

Apparently, Ms. Do, there -- there are no statements. Doesn't this just include an oral statement? We did a lot of litigation at one time about when attorneys' notes might constitute a statement. And I had drafted one order and then trimmed it down some when I thought it was taken care of.

You asked for a reconsideration or clarify. There was a lot of litigation on that.

Apparently there are no statements. So I don't know what you mean under 15.3 -- I'm sorry. 15.1(e)(3), what they would be providing to you or why there would be an interview or -- on these kinds of things.

Basically, what I'm hearing is the defense -- I'm sorry -- the state is providing

information that has come up at trial and they're going to be asked about, I think --

MR. HUGHES: Your Honor --

THE COURT: -- anticipate.

Mr. Hughes.

MR. HUGHES: I apologize for interrupting. I do want to correct one thing. About two weeks ago I had a very brief conversation with Dr. Mosley and asked him about organophosphates. There were no notes taken. It was literally on my cell phone in the car when we had heard about organophosphates in the trial.

Dr. Mosley indicated he didn't believe that organophosphates could cause this. And that was, basically, the end of the conversation.

I did want to make sure that was on the record.

THE COURT: Ms. Do, again, I didn't want to interrupt. I just want to address these issues as they come up.

MS. DO: Thank you, Your Honor. If the state is making the representation and the Court is accepting that representation that there will be nothing new beyond what I received in the report already disclosed, then I will sit down.

But Mr. Hughes has indicated that he's going to ask the medical examiners for additional opinions regarding other causes of death. We're now learning about a conversation he had two weeks ago.

I'm entitled to know what the experts' opinions are in this case. And if those opinions are going to be beyond the four corners of the autopsy report that we received, beyond the interviews that we've conducted in May and January, then -- then I am entitled to that.

But if the state -- if Mr. Hughes is indicating that nothing has changed, the Court's accepting that, then I would anticipate tomorrow's testimony to be exactly what I anticipated before we received the 49th disclosure. But I'm not confident that that's going to happen.

The second issue, Your Honor, Mr. Hughes said something about allowing experts to testify regarding other evidence. I will -- and if the Court wants to come back to this we can.

The medical records of Daniel Pfankuch is not otherwise admissible evidence. The Court's made ruling regarding that. I don't know whether or not these experts are going to now make an

opinion or render an opinion about cause of death relying on prior incidents.

I'd like to separate out what a medical examiner -- what an expert can base his opinion on and focus on the disclosure issue. I'm receiving this information this morning, and they're testifying tomorrow.

THE COURT: And I was trying to focus on that too. And you just said if there's not going to be a change of opinion, you don't think there is a disclosure opinion.

MS. DO: Correct. But if Mr. Hughes is going to -- if he can --

THE COURT: With regard to the 2005 Pfankuch?

MS. DO: Right.

THE COURT: Okay.

Well, what about that, Mr. Hughes.

MR. HUGHES: Your Honor, again, I think the state can ask the doctor if he's reviewed medical records from prior participants. And without going into the content, which would be implicated under Rule 703, the rules of evidence, Rule 703 sets forth two ways that an expert can testify about the facts and opinions that they're -- the fact that they're opinion are based upon.

Under one method it would be appropriate when I lay foundation to ask the Court to allow that fact, the underlying fact, the content of those reports to come into evidence. The other way would be simply to ask the expert without going into the content of the underlying medical reports.

If the Court determines that the underlying reports don't come in under Rule 703, then I can't go into the -- into the meat of what's in those reports, but I can ask if he's seen the reports and if those have affected his opinion.

And if they have affected his opinion, how have they affected his opinion? And I believe that the rule is very clear on that point.

It's appropriate, again, for the state to ask the expert if this information changes the expert's opinion about the cause of death of those two victims. And, again, it's my belief the expert's opinion as to the cause of death will not change.

But these are additional questions that have arisen since this trial has started, that it is appropriate to ask would this information make any difference? And, if so, how would it make a difference to you reaching your opinion?

THE COURT: I thought we were talking just about the 2005.

MR. HUGHES: I'm sorry, Your Honor. With respect specifically to the 2005 records, that's correct. But there's the other issue that Ms. Do had brought up, which regards the rat poison and which regards the medical records of the other participants.

And Ms. Do had brought those up at the beginning of our argument today and then -- because those are some of the other things that were transmitted to the medical experts -- to the medical examiners.

THE COURT: Ms. Do.

MS. DO: Your Honor, it still isn't clear to me whether or not there will be new opinions or not. I accepted Mr. Hughes' representation earlier that there would not be. And now listening to his argument, there seems to be additional opinions and conclusions.

For one thing, Rule 703 states that information that is otherwise not admissible cannot be revealed just through an expert. And it seems to me that this is another back-door attempt to get in the prior acts this Court has repeatedly ruled

is not admissible until the state can establish the condition precedent to allowing those in.

Mr. Hughes then went forward and said that based upon the 2005 information, the rat poisoning, the wood, pesticides, whatever new information was obtained, the medical examiner is going to offer an additional opinion that was not previously disclosed to us in the autopsy report.

Again -- you know -- it's quarter to five, Your Honor. We're supposed to be able to cross-examine these witnesses tomorrow, and we're talking about information that just got revealed to us this morning.

And the state still has not proffered an excuse to the Court as to why it held on to this information. They could have told us on March 24th that they were doing this. They could have told us again on March 28th when they sent the second batch of information. Why are we just getting this this morning, the day before they're going to testify?

THE COURT: Again, you're going to start with Dr. Lyon tomorrow?

MR. HUGHES: Yes, Your Honor.

THE COURT: Okay. I'll ask the attorneys to be here by 8:30 -- the parties to be here by 8:30.

And I'm going to focus just on Dr. Lyon for tomorrow. There's other issues with regard to the Hamiltons perhaps.

We're in recess.

Mr. Hughes.

MR. HUGHES: Your Honor, there is one other issue pertaining to Dr. Lyon. Earlier in the proceedings of this case there is some questions of a witness regarding a discovery dispute. The Court indicated, I think in a bench counsel, that that was not appropriate. Parties have ways of subpoenas and that sort of method.

With respect to the medical examiners, there -- there was a discovery dispute between the parties -- the Court's aware of that -- that ultimately resulted in a court order that we allow a second interview of the medical examiners.

It's the state's opinion that the existence of that discovery dispute, it would not be an appropriate area to go into with the witness. Those -- those are matters that came up between the lawyers. They're not facts of the case. They're not relevant to the case and really would be a collateral issue as to why the state raised that discovery dispute.

And I don't know if the defense intends to ask the medical examiners, if the state disallowed them originally to answer questions and then later they were allowed to answer questions. But I would ask that the Court direct the defense, if they intend to do that, that those sort of discovery disputes are not appropriate.

THE COURT: And I believe that was one of the issues that was just in a motion that collected several possible trial issues that we were going to defer until it arose. And it's here.

Who would be cross-examining Dr. Lyon?

Ms. Do?

MS. DO: I am, Your Honor. I don't recall being privy to that bench conference. I'm not sure what -- what the conversation was. I do believe, depending on direct examination, it could be relevant because it goes to the credibility of these witnesses.

The state took the position that these medical examiners were but a mere extension of their office and exerted control in instructing these witnesses to not answer questions that went directly to the material issues in this case. The witnesses accepted that instruction.

I think that it is relevant and probative for the jury to hear that when the defense tried to inquire about the opinions, the discussions, and conversations, investigation as to the cause of death, they were instructed to not answer. That goes to whether or not these are independent witnesses -- they're supposed to be -- but each and every one of them accepted the instruction of the attorneys to not answer questions. I think that's clearly relevant.

THE COURT: Mr. Hughes.

MR. HUGHES: Your Honor, it's not relevant. Clearly the -- Ms. Do can ask the witnesses who's employing them, who did you do the work for in this case. But with respect to the specific discovery -- discovery dispute, that was an issue between the lawyers. It doesn't pertain to the facts of the case. The jury is not aware of what the discovery rules are, Rule 15.1 and 15.2, and it raises collateral issues as to why the state took that position.

I do realize -- and I respect that the state was wrong in that position that we took. But it does raise the collateral issue. And then do we go into, well, why did the state take that? And is

that collateral issue relevant?

And then it raises the issue, even as Ms. Do suggests that there's some relevancy -- and honestly, I don't see the relevancy. If there is, the undue prejudice and the confusion of the issues that's created by interjecting that collateral issue into the trial clearly outweighs any of the marginal relevancy it might have.

THE COURT: Did you have anything additional, Ms. Do, on that?

MS. DO: Judge, these are the medical examiners on the cause of death in this case. Their credibility is squarely an issue and something that is very important to the defense.

These attorneys took the position that they were covered by work product. This Court through litigation determined that that was not a meritorious ground and imposed sanctions.

I'm not asking to get into the fact that sanctions were imposed. I don't think we don't need to get into the fact that a work product claim was raised unmeritoriously.

I think what's relevant to the jury to know is that these medical examiners, rather than abiding that their statutory duty under Arizona law

to be independent, instead conducted themselves as a mere extension of the County Attorney's Office.

Now, that is relevant evidence for there jury to consider in determining whether or not the credibility of their ultimate opinion on the cause of death in this case is in question.

THE COURT: And I -- I agree. There can be some cross-examination on that. There does not need to be anything discussed about a discovery dispute or sanctions or anything of that nature. But in asking questions and then not answering questions, that's -- that's relevant areas of inquiry. But not -- not extensively, Ms. Do.

MS. DO: I understand.

THE COURT: Mr. Hughes is right. That's -- gone through this before in other context too. But there's real element of just having a collateral issue here. But --

MS. DO: Your Honor, I need some additional guidance. Is the Court determining whether or not the medical examiner will be able to testify to the 2005 medical records of Daniel P.? Or is that something that --

THE COURT: Well, I'm going to see you at 8:30. But --

MS. DO: Okay.

THE COURT: -- no one has provided a case to me or any -- any straight law on that. It's just been -- there have been arguments. And Mr. Hughes cited the rule. 703 discusses the rule if it's information that an expert would normally rely on it's -- that can be something that they consider.

MS. DO: I understand, Your Honor. But shouldn't the defense have an opportunity to speak to the medical examiners, interview them, regarding what it is that they believe these records show or don't show?

THE COURT: And there's case law on that too about when an expert appears at trial and has additional information. There's at least one case, I believe, that's really squarely on this. I'm going to look at that.

But the guide is going to be Rule 703 with regard to specific mention of other times.

Mr. Hughes, you weren't intending to do that, were you?

MR. HUGHES: Your Honor, I was going -- I was going to ask the expert pursuant to 703 the basis upon which his opinion is formed. The contents of those medical records, if the Court does not permit

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them to come in under the provision in 703, then 703 is clear. I can ask the basis of the opinion, but I can't go into facts that are in that report.

THE COURT: What's the opinion? What -- what opinion are you going to be presenting?

MR. HUGHES: I -- I will be asking opinion as to the cause of death of the two victims, and I'll be asking the bases upon which that opinion was based, including was that opinion based upon information -- medical records of prior participants inside the sweat lodge on prior years.

THE COURT: And you're saying at the time you interviewed him, he had not looked at those other documents?

MS. DO: No, Your Honor. The state has never provided Daniel P.'s medical records to any medical examiner until, it looks like, March 28th. And -- and I think the suggestion that he could simply question the medical examiner on the basis and -- and dangle in front of jury that there exists some medical records from a 2005 incident without allowing full inquiry into that, essentially we're -- we're given a very difficult choice.

He can dangle it in front of the jury but we can't fully cross-examine on it because it is

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inadmissible. And it was our motion to exclude it. The Court granted it. And now we're going to back door it in through an expert testimony. That just does not square with Rule 703 or with the Court's prior ruling.

MR. HUGHES: And, Your Honor, I'm not sure at this point it is inadmissible. The Court issued a limited ruling about prior incidents, indicated that we needed to get expert medical testimony that would explain the relevance of the prior symptoms. We have --

THE COURT: Mr. Hughes, I've also indicated that if there's going to be testimony -- evidence about prior sweat lodge incidents, it has to be of the type that has appropriate foundation, and it also has to be the type that would indicate that -- well, it came up in another context -- but Mr. Ray had knowledge of that as well.

So to go into the specifics at all, have the doctor look at that and then offer an opinion, would really be going around the ruling as it stood when the 404(b) was litigated.

MR. HUGHES: And, Your Honor, with respect to that, it was my understanding that the Court issued directives on two ways that that evidence could be

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relevant. One is to causation and one is to Mr. Ray's knowledge of what was occurring to participants on prior occasions.

With respect to the causation issue, was it a sweat lodge that Mr. Ray runs or is it some sweat lodge that someone else runs where there aren't problems? The issue that people may have had these same heat-related illnesses in the past doesn't pertaining to his knowledge of it. It's solely focused on the causation elements.

Your Honor did direct that if we were going to try to use that evidence to try and show that Mr. Ray had knowledge with respect to the state's burden of proof on the mens rea issue, that we did have to show that it occurred somewhere where Mr. Ray could have seen it.

But with respect to the causation issue only, I believe the medical record, Your Honor directed that there be clear and direct evidence of what the symptom was that was being gleaned. And that would be something that would be documented in the medical record. And then Your Honor directed that we also had to show that that was somehow relevant to a heat-related illness.

With the testimony now that we've had

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from Dr. Cutshall and with the testimony earlier from Dr. Armstrong, I believe we have laid that -- that preliminary hurdle that the Court set for us to show why is Mr. Pfankuch's symptom, which the Court heard about at the prior hearing -- why are those, first of all, relevant to heat-related illnesses?

The experts have testified about people becoming combative and -- and becoming disoriented and the other things that are documented in Mr. Pfankuch's records. And that goes squarely just to the issue of causation.

So with respect to admissibility, I believe we've met that records -- that threshold now. Rule 703 and the other Rules of Evidence allow admissible evidence to be explained to the jury.

If Your Honor makes the ruling tomorrow morning that it's not going to come in, then I won't go into the facts of the opinion itself or the medical records.

But 703 does talk about the facts or data in the particular case of which one expert bases an opinion or inference, maybe those perceived by or made known to the expert at or before the hearing.

And then it goes on to say, if of a type reasonably relied upon by the expert in the field. And it says, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted.

And if it's Your Honor's ruling tonight or tomorrow morning that we haven't met that threshold to talk about Mr. Pfankuch, then we'll respect that. We won't go into the facts. But we are allowed to -- to go into the opinion itself.

MS. DO: Your Honor, I believe it was perhaps a week or a week and a half ago when this Court again stated that it is very misleading for the state to characterize the 2005 or any of the prior incidents as being similar to what we're talking about in 2009.

They have not met the condition precedent that this Court has continually notified them of in order to get this evidence in. There's a competent way to do it. They haven't done it. But they now tell me the day before this expert is it is going to testify that they're going to elicit a new opinion. And that is that 2005 somehow is notice that there's a risk of death or notice that there's a risk of heat stroke. I've not had the

opportunity to question the expert about that.

You know, we came out to Arizona twice, Your Honor, to interview these experts. And the Court -- the state could have during the 17 months this case has been pending provided the medical examiners with Daniel P.'s record, which they had as of November 2009.

I think it's really unfair to expect the defense to be able to cross-examine this expert without knowing what answer he's going to give.

So unless the court is at this point ready to preclude the medical examiners from going into the 2005, then we are asking under due process for the opportunity to interview these medical examiners. That is a very light remedy given the fact that we're getting late disclosure today.

THE COURT: I'll see you at 8:30 tomorrow. Thank you.

(The proceedings concluded.)

STATE OF ARIZONA)
) ss: REPORTER'S CERTIFICATE
COUNTY OF YAVAPAI)

I, Mina G. Hunt, do hereby certify that I am a Certified Reporter within the State of Arizona and Certified Shorthand Reporter in California

I further certify that these proceedings were taken in shorthand by me at the time and place herein set forth, and were thereafter reduced to typewritten form, and that the foregoing constitutes a true and correct transcript.

I further certify that I am not related to, employed by, nor of counsel for any of the parties or attorneys herein, nor otherwise interested in the result of the within action.

In witness whereof, I have affixed my signature this 10th day of April, 2011.

MINA G. HUNT, AZ CR No. 50619
CA CSR No. 8335

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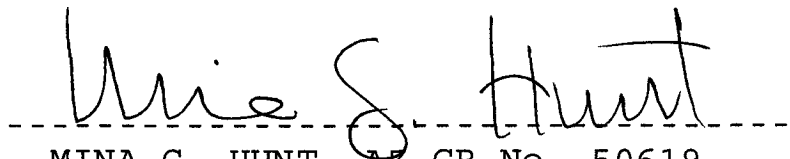

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